Regulation 28: REPORT TO PREVENT FUTURE DEATHS

NOTE: This form is to be used **after** an inquest.

	REGULATION 28 REPORT TO PREVENT DEATHS **THIS REPORT IS BEING SENT TO:** **1 Calderdale and Huddersfield NHS Foundation Trust**
1	**CORONER** I am Charlotte KEIGHLEY, Assistant Coroner for the coroner area of West Yorkshire Western Coroner Area
2	**CORONER'S LEGAL POWERS** I make this report under paragraph 7, Schedule 5, of the Coroners and Justice Act 2009 and regulations 28 and 29 of the Coroners (Investigations) Regulations 2013.
3	**INVESTIGATION and INQUEST** On 13 November 2024 I commenced an investigation into the death of Kore Elizabeth PADGETT aged 90. The investigation concluded at the end of the inquest on 13 August 2025. The conclusion of the Inquest was that Kore Elizabeth Padgett died as a consequence of naturally occurring disease contributed to by injuries sustained from an accidental fall requiring immobilisation in a hard collar. Kore struggled to tolerate the placement of the collar with it impacting upon her overall health and ability to swallow, placing her at high risk of aspiration and requiring the assistance of a nasogastric tube for feeding.
4	**CIRCUMSTANCES OF THE DEATH** In the early hours of the 8th September 2024, Kore Elizabeth Padgett was admitted to Huddersfield Royal Infirmary following an accidental fall down the stairs at home. In the course of her admission, Kore experienced pain in her neck and was subsequently diagnosed with an unstable fracture to her neck, requiring immobilisation in a hard collar. Kore had previously undergone extensive surgery on her neck and given her age and associated frailty, she struggled to tolerate the placement of the collar, which impacted upon her ability to swallow requiring the aid of a nasogastric tube for feeding purposes. The pressure applied by the collar caused Kore to develop three separate pressure sores and she experienced further difficulties as the collar was noted to move whilst in situ, with the staff on the ward being unable to appropriately adjust the collar as they had not be trained to do so. Kore's care was managed in part through the tissue viability nurses who experienced difficulties in providing pressure relief as a consequence of the ongoing requirement for Kore to wear the collar. On the 2nd October 2024, advice was sought from the neurosurgical team in Leeds as to the ongoing need for the collar and on the basis of the information provided at the time, advice was given to continue with the use of the collar until Kore could be assessed by the neurosurgical team. A request was made for Kore to be assessed within a week but this was not arranged. Kore's health continued to deteriorate and she went on to develop aspiration pneumonia, requiring chest physiotherapy which was limited by the placement of the collar. No further contact was made with the neurosurgical team to discuss the ongoing effects of the collar on Kore's physical health and therefore Kore was unable to make an informed decision as to whether or not she wanted to continue wearing the collar or could remove it and accept any associated risks.

	Kore went on to develop recurrent aspiration pneumonia and on the 23rd October 2024, despite having previous periods of improvement, her condition rapidly deteriorated and she passed away.
5	**CORONER'S CONCERNS** During the course of the investigation my inquiries revealed matters giving rise to concern. In my opinion there is a risk that future deaths could occur unless action is taken. In the circumstances it is my statutory duty to report to you. The **MATTERS OF CONCERN** are as follows: (brief summary of matters of concern) i) The absence of training for staff on the ward in respect of the correct fitting of a hard collar; ii) The absence of communication by the treating clinicians with the neurosurgical team at Leeds in respect of treatment options for Kore given the significant impact that the wearing of the collar was having on Kore with the development of pressure sores, difficulties with her swallow and increasing risks of aspiration. iii) The absence of any consideration of the risks versus benefits of wearing the collar and consequently the lack of opportunity for Kore to consider the risk versus benefits and make an informed decision as to how she wanted to proceed. iv) The lack of communication between professionals providing care on the ward and the concerns they were raising as to the impact of the collar upon Kore's health and the absence of any consideration of those concerns by those in charge of Kore's care with no multi-disciplinary approach as to the available treatment options or further assessments which could have been undertaken.
6	**ACTION SHOULD BE TAKEN** In my opinion action should be taken to prevent future deaths and I believe you (and/or your organisation) have the power to take such action.
7	**YOUR RESPONSE** You are under a duty to respond to this report within 56 days of the date of this report, namely by October 23, 2025. I, the coroner, may extend the period. Your response must contain details of action taken or proposed to be taken, setting out the timetable for action. Otherwise you must explain why no action is proposed.
8	**COPIES and PUBLICATION** I have sent a copy of my report to the Chief Coroner and to the following Interested Persons [redacted] I have also sent it to **The Leeds Teaching Hospitals NHS Trust** who may find it useful or of interest. I am also under a duty to send a copy of your response to the Chief Coroner and all interested persons who in my opinion should receive it. I may also send a copy of your response to any person who I believe may find it useful or of interest.

	The Chief Coroner may publish either or both in a complete or redacted or summary form. He may send a copy of this report to any person who he believes may find it useful or of interest. You may make representations to me, the coroner, at the time of your response about the release or the publication of your response by the Chief Coroner.
9	**Dated: 28/08/2025**  **Charlotte KEIGHLEY** **Assistant Coroner for** **West Yorkshire Western Coroner Area**