REGULATION 28: REPORT TO PREVENT FUTURE DEATHS (1)

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

	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO:** **Chief Executive – Hull Royal Infirmary**
1	**CORONER** Miss Lorraine Harris, Area Coroner, East Riding of Yorkshire and City of Kingston Upon Hull.
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 17th February 2025 I commenced an investigation into the death of Raymond LEAKE, aged 83 years. An inquest was opened on 25th February 2025 and the investigation concluded at the end of the inquest on 28th October 2025. The conclusion of the inquest was: *FALL* The following findings of fact were made: • *Mr Leake was regarded as medically fit for discharge on 13th February 2025 but due to the lateness of the hour it was decided that he should remain in hospital until collection on 14th. Reasonable decision.* • *It is noted that medically fit for discharge refers to the fact that there was little that could not be done in the community to assist him, rather than him remaining in hospital.* • *Mr Leake was on Ward 90 at Hull Royal Infirmary. On the evening of 13th February 2025 there were reduced staff numbers. There should have been 3 registered nurses and there were only 2. It would be unsafe to assume exactly whether the appropriate staff number on duty would have prevented the fall but acknowledged that there was inadequate staffing on the evening of the incident.* • *That evening, at approximately 8.20 pm Mr Leake fell while trying to put his shoe on. He hit his head and sustained a laceration. The fall was witnessed by a nurse who promptly attended Mr Leake to assist.* • *Following the fall, the nursing team followed the protocol for seeking*

assistance from a doctor. The bleeped doctor was busy, but again the nursing staff followed advice to seek timely assistance. A nurse practitioner arrived and assessed Mr Leake.

- *Despite the injury to the back of his head, at the time of assessment, Mr Leake did not present as confused, he also at that time, remained able to mobilise.*
- *The nurse practitioner appropriately followed protocol and a CT scan was requested at 2110 hours on 13th February 2025, it was regarded as an urgent scan.*
- *This scan was authorised appropriately but for reasons unknown the radiology department did not book Mr Leake to attend for a CT scan. It was heard in evidence this was likely due to human error.*
- *Evidence was heard that when a patient is on anti-coagulant medication then a trauma CT scan should be conducted within 8 hours. The scan was not conducted until 1044 hours on 14th February 2025. This is 13 hours and 33 minutes after the incident, over 5 ½ hours after the optimum recommended time.*
- *Due to poor standard of record keeping the appropriate number for the family point of contact was not recorded in the correct location on the hospital computer system. As such, the agreed point of contact for the family of Mr Leake was not informed.*
- *At approximately 0330 hours on 14th February 2025 the nursing staff requested a doctor to attend to review the laceration. The dressing was changed. The nurse appropriately raised the concern that the CT scan had not yet been done, and he was instructed to continue with observations and await the CT scan. It is evident that the doctor did not chase the CT scan.*
- *The night nursing staff carried out observations in line with the protocol. There was no record of the expected 0130 hour observation however both before and after this Mr Leake's GCS was 15/15.*
- *On the morning of 14th February 2025, the night nursing staff handed over to the day nursing staff, this included that fact that Mr Leake had sustained a fall and the CT scan was yet to be conducted. The seriousness of the delayed CT scan was underestimated at this point as at this time Mr Leake was still presenting as no significant concern.*
- *While I have heard it is the task of the medical team to request and review scans, it would have been entirely appropriate for the Nursing Sister to chase the delayed scan.*
- *On the morning of 14th February 2025, the radiology department attempted to telephone the ward 4 times to arrange seeing Mr Leake. Due to a high workload the phone was not answered. The CT department did not do anything further to address the missed scan. I understand that now there is a process in place for porters to attend the wards and collect patients.*
- *A nurse was allocated to care for Mr Leake and at approximately 0815 hours, he appeared to be using his hand in a phone like manner. This was escalated to the Nursing Sister. When seen by the Nursing Sister*

there were at that stage, no further signs of confusion and he remained sitting in his chair.

- *At approximately 0830 hours the Nursing Sister approached a consultant who was visiting other patients on the ward. Evidence was heard that she passed over details about the fall, the cut and the delayed CT scan, the Doctors evidence was that he was not made aware of any concern only of the fall. I have considered this contradiction, and I find that, again, the significance of the head injury and the delayed CT scan were underestimated by hospital staff and as such there was no level of concern that was conveyed in that conversation.*
- *Evidence was heard that Mr Leake was under constant supervision from this point, I do not find this credible, as when Mr Leake's family arrived to collect him, they found Mr Leake unresponsive. The Registrar that reviewed him found his GCS level was reduced to 7/15*
- *When the Falls Team attended at approximately 0930 hours they conveyed Mr Leake themselves for the CT scan which revealed a catastrophic bleed.*
- *Given Mr Leake's comorbidities had the bleed been identified earlier the outcome would not have changed, Mr Leake's comorbidities would have prevented him from being a candidate for surgery. Evidence was heard that, although the anticoagulants could have been stopped sooner, there was nothing that could have stopped the bleed and no other treatment options would have been available if the scan had been conducted within the appropriate time. I can understand that family feeling if the scan results had been revealed earlier, when Mr Leake still had capacity, he may have requested an operation however, it would be unsafe to say that this is what he would have said, and further it was a clinical decision that an operation was simply not viable – it is not a case that a person can demand an operation. I agree, however, that the delay in the scan and lack of communication with the family removed their option visit and spend time with Mr Leake while he was still conscious.*
- *The lack of communication to the family is compounded by the fact that the hospital had been in contact with the daughter of Mr Leake on several occasions, so her contact details were on the system.*
- *The sad knowledge that the outcome would not have changed in this case does not detract from the fact that the process for CT scanning of such injuries was not followed. The identification of injuries may, in certain cases allow for timely treatment and alternative care.*
- *I have heard evidence that following Mr Leake's death certain processes were put in place in March, however due to lack of staff these processes have not been audited. It is therefore impossible to say whether the suggested changes are sufficient or insufficient to ensure this issue will not be repeated. CT's are vital to identify medical issues and, although not in this case, they may provide an opportunity for medical staff to prevent death. Without the required audit results I am concerned that there could be a flaw within the system at the hospital and therefore I will submit to them a RPFD raising my concern. A HMC cannot request a*

	particular action but can place the responsibility in the hands of the organisation responsible to review what can be done. Box 3 of the record of inquest read: *On 13th February 2025 Raymond Leake had been deemed medically fit to be discharged home following a stay in Hull Royal Infirmary for pneumonia, severe left ventricular failure, systolic dysfunction and bilateral pleural effusions. A decision was made that he would be collected on 14th February 2025 by family. On the evening of the 13th February Mr Leake was witnessed to fall and bang his head while he was attempting to put on a shoe. In line with hospital policy, a CT head scan was requested at 2110 hours. As Mr Leake was on anti-coagulant medication the CT scan should have been conducted within 8 hours. For unidentified reasons, likely human error, the authorised scan was not booked by the radiology department. It was only following deterioration that Mr Leake was conveyed for an urgent CT scan at 1044 hours on 14th February, some 13 and a ½ hours later. The CT scan revealed an unsurvivable catastrophic head injury and Mr Leake was placed on end-of-life care. He died on 16th February 2025.* His medical cause of death was recorded as: 1a Subdural and Subarachnoid haemorrhage. 1b Witnessed Fall 2 Bronchopneumonia
4	**CIRCUMSTANCES OF THE DEATH** Raymond LEAKE sustained a fall after being deemed medically fit for discharge from the hospital. The falls protocol was followed, and a CT head scan was requested and authorised. This scan should be carried out within 8 hours. The booking of the scan was not done by the radiology department. No reason could be found for this not being done. When the scan was done some 13 ½ hours after the incident it revealed a catastrophic bleed.
5	**<u>CORONER'S CONCERNS</u>** During the course of the inquest the evidence 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. – 1. During the evidence it was heard that efforts were made to review why the scan was missed. No exact reason was found, and it was believed

	likely human error. It was acknowledged that a number of processes had been put into place in March in an effort to improve the radiology scanning processes including training, markers and portering; however, the audit of these new processes was still not completed by the time Mr Leake's death came to inquest. I was informed the believed reason for not reviewing the audit was staff numbers. This meant that I could have no reassurance that these processes are working appropriately or that further urgent scans would not be missed in future.
6	**ACTION SHOULD BE TAKEN** In my opinion action should be taken to prevent future deaths and I believe your department/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 23rd December 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 family of Mr Raymond LEAKE • The ICB 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 other 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. She 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.
9	**[DATE]** **[SIGNED BY CORONER]** ***28th October 2025*** ***Lorraine Harris***