

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 3 rd March 2025 I commenced an investigation into the death of Kathleen Rose WARD, aged 76 years. An inquest was opened on 7 th March 2025 and the investigation concluded at the end of the inquest on 3 rd November 2025. The conclusion of the inquest was: <i>NARRATIVE: Natural causes contributed to by industrial disease</i> The following findings of fact were made: • <i>Mrs WARD diagnosed with malignant mesothelioma in October 2022 following a biopsy.</i> • <i>Mrs WARD had exposure to asbestos both via her own working life but also by washing her husband's clothes which were covered in dust (he detailed working with asbestos). Evidence was heard of freely circulating asbestos fibres both of those scenarios.</i> • <i>When gravely ill, on 19th February 2025 there were no available beds at the Queens Centre which would be appropriately equipped to deal with patients at end of life. Mrs Ward therefore had to be taken to the emergency department at Hull Royal Infirmary. For 21 hours there were no suitable beds available. It is expected that a suitable bed should be found within 4 hours. This meant that Mrs Ward was in a location that did not have the specialism, the medication, or the privacy to care for her in her final hours.</i> • <i>The lack of understanding lead to issues over appropriate pain relief being administered to Mrs Ward in a timely manner.</i>

	• <i>At a time that it was evident to the family that Mrs Ward was approaching end of life, she was moved unnecessarily from a quiet room to a 6-bay location, she died very shortly afterwards. I can only echo the words of a nurse, it was not acceptable or dignified.</i> • <i>I have heard that where beds are not available at Queens Centre, patients are taken to the Emergency Department. Since Mrs Ward's death I have heard that although some processes are in place to try to prevent patients on palliative care being taken to the Emergency Department (bed modelling and capacity), it still occurs at least once a week, and that there has been no increase in the bed space available at the Queens Centre. Beds at Queen Centre treat both those with life limiting conditions, on palliative care and those on end of life care. The lack of bed space means that people are still being treated in unsuitable environments, by staff who do not have a specialism in palliative care and medical pain relief required at end of life. This also means those with life limiting illnesses will not be treated appropriately to alleviate symptoms before end of life to prolong and give pain free/limiting treatment. Space being taken up in the Emergency Department also means that those requiring life saving emergency treatment may be delayed in receiving appropriate care. RPF.</i> Box 3 of the record of inquest read: <i>Kathleen Rose Ward, aged 76 years, died from pneumonia at Hull Royal Infirmary on 20th February 2025. Mesothelioma, Immunotherapy induced myocarditis and chronic kidney disease contributed to her demise. Mrs Ward suffered breathlessness in April 2021, underwent a biopsy in September 2022 and was diagnosed with malignant mesothelioma in October 2022. Evidence was heard that she was exposed to freely circulating asbestos fibres during her own working life but also when she washed her husband's overalls throughout a period of time when he reported working with asbestos.</i> Her medical cause of death was recorded as: 1a <i>Pneumonia</i> 2 <i>Mesothelioma, Immunotherapy induced myocarditis, chronic kidney disease</i>
4	CIRCUMSTANCES OF THE DEATH Mrs Kathleen Rose WARD had been diagnosed with terminal mesothelioma. On 19th February 2025 she was admitted to the emergency department at Hull Royal Infirmary as no beds were available at Queens Centre. Queens Centre would have been a place where Mrs WARD would have received appropriate care and medications for end of life. Due to the lack of bed space, Mrs WARD remained in the emergency department - a location where staff are trained to try to save life rather than deal with chronic illness and

	end of life care. Mrs WARD had no dedicated specialist care, inappropriate pain relief and encountered treatment, that although not within the HM remit, was acknowledged by the hospital to be unacceptable. I noted that other issues were to be taken up directly by the hospital and do not form part of this report.
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 the emergency department still has people being held in their department who should be getting ward based care. Additionally, that there has been no increase in the bed space available for Queens Centre. This meant that I could have no reassurance that the circumstances of Mrs Ward's death would not be repeated, but also that people requiring emergency treatment may be delayed in receiving the appropriate emergency care.
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 29th 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 Mrs Kathleen Rose WARD • The ICB • Other interested persons (Hull City Council, Hull University, Frederick Singleton (ceased trading)) 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] <i>3rd November 2025</i> <i>Lorraine Harris</i>