ANNEX A

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:** **1. Hull University Teaching Hospital** **2. NHS** **I am also sending this to the family of Mrs Patricia Irene Walker.**
1	**CORONER** I am Sally Robinson, Assistant Coroner, for the coroner area of 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 11th April 2025, an inquest was opened and adjourned into the death of Patricia Irene Walker aged 87 years. The investigation concluded at the end of the inquest on 27th January 2026, the conclusion of the inquest was accidental death. Patricia Walker died in Castle Keep Care Home in Bransholme in Hull after being placed on fast-track discharge following an emergency admission to Hull Royal Infirmary. Her medical cause of death was recorded as: 1a. Acute on chronic bilateral subdural haematoma 1b. Multiple falls 2. Fractured neck of femur (operated), frailty of old age
4	**CIRCUMSTANCES OF THE DEATH** Patricia Walker lived independently and, although had suffered some confusion and falls in the community, was able to look after herself and visited he husband in Castle Keep care home. She had a supportive family and decided she wanted to live closer to her nieces. She went with her niece to visit a bungalow with view to moving but tripped over shrubbery in the garden of the property and was conveyed by emergency ambulance to Hull Royal Infirmary where she was found to have suffered a fractured neck of femur. She was assessed as a falls risk as she was confused whilst on Ward 12 where she was placed from ED. Ward 12 is a trauma orthopaedics ward. She was admitted on 4th

	February and fell from the bed which had bed rails up at 03:40hrs. She suffered a head injury and was sent for a CT later that day at 09:47hrs. The scan revealed an acute bilateral subdural haematoma on chronic subdural haematoma which would need to be treated with burrhole surgery. This operation took place on 10th February; her fractured neck of femur having been operated on 9th February successfully but her neurological condition having deteriorated. The operation went ahead as planned but Mrs Walker suffered further falls whilst in hospital when she was transferred to Ward 90 which is one of the five frailty wards in the hospital. Staffing was sub optimal on Ward 90 at this time, with the staffing model being below the required four RGNs and three unregistered nurses on a day shift and three RGNs and two registered nurses on a night shift. One of the RGNs had been moved to a different ward leaving the ward short staffed on the night shift of 24th February. Mrs Walker suffered a further two falls whilst on Ward 90. Mrs Walker was placed on fast-track discharge and died in Castle Keep care home having ultimately failing to rally with poor nutritional intake and medication refusal and worsening confusion.
5	**CORONER'S CONCERNS** During the course of the inquest the evidence revealed matters giving rise to concern. In my opinion there is a risk that future deaths will 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) Staffing was sub optimal and remain sub optimal on Ward 90 as recruitment is difficult which means that TAG nursing care is not always possible, and patients are at an increased risk of falls.
6	**ACTION SHOULD BE TAKEN** In my opinion action should be taken to prevent future deaths, and I believe your organisation has 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 25th March 2026. 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: the family of Patricia Irene Walker, Hull University Teaching Hospital and Barchester Healthcare as well as the people stated above I am also under a duty to send the Chief Coroner a copy of your response. 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	**[DATE]** **[SIGNED BY CORONER]** ***28th January 2026*** ***Sally Robinson, Assistant Coroner***