

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. Chief Executive HUTH
1	CORONER I am Professor Paul Marks, Senior Coroner, for the Coroner Area of City of Kingston Upon Hull and the County of the East Riding of Yorkshire.
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 12 th January 2026, I commenced an investigation into the death of Raymond John MORAN, aged 82 years. The investigation concluded at the end of the inquest on 11 th February 2026, the narrative conclusion of the inquest was:- Raymond John Moran had an unwitnessed fall on 13th December 2025 whilst a patient on ward 32 at Castle Hill Hospital which resulted in a subtrochanteric fracture of his right femur. This in conjunction with his co-morbidities, including metastatic prostate cancer and bilateral pulmonary emboli, more than minimally, negligibly or trivially contributed to his death on 24th December 2025.
4	CIRCUMSTANCES OF THE DEATH Raymond John Moran had a significant history of metastatic prostate cancer, ischaemic heart disease and atrial fibrillation for which he received apixaban. He has a fall at his home on 31st October 2025 which resulted in the development of a fracture of the left femoral neck. This was successfully treated surgically, and he went into rehabilitation thereafter. Whilst there, he developed breathing difficulties which were investigated and were found to be due to bilateral pulmonary emboli, which occurred even in the presence of anticoagulant therapy for his atrial fibrillation. He was readmitted to hospital and his anticoagulation therapy increased. Whilst on Ward 32 at Castle Hill Hospital, he had an unwitnessed fall which resulted in a subtrochanteric comminuted fracture of the right femur. Due to his anticoagulation requirements and diminished physiological reserve, although consideration was initially given for him to have further surgery, it was subsequently ruled out due to his co-morbidities. He died on the 24th December 2025. Although a falls risk assessment had been carried out and Raymond adjudged as a moderate risk, in retrospect, he should have been categorised as a high risk of falling. His fractures were not due to metastatic deposits in the femora but were osteoporotic, and this disorder was contributed to by the treatment he had received, which included dexamethasone for his prostatic cancer. The fall on ward 32 more than minimally, trivially or negligibly contributed to his death although his life span was unlikely to have been long due to his known comorbidities.

5	<p><u>CORONER'S CONCERNS</u></p> <p>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.</p> <p>The MATTERS OF CONCERN are as follows. –</p> <p>Evidence was heard at inquest that not only was the falls risk assessment inaccurate, but also, it was not updated as it should have been. In addition, the documentation was incomplete.</p>
6	<p>ACTION SHOULD BE TAKEN</p> <p>In my opinion action should be taken to prevent future deaths and I believe you and your organisation has the power to take such action. This may include, for example, ensuring that appropriate assessments take place that capture all relevant information about falls that have recently taken place in the community, emphasis is placed on filling out forms accurately and contemporaneously, and ensuring training and auditing of in-hospital falls continues and can be demonstrated and evidenced.</p>
7	<p>YOUR RESPONSE</p> <p>You are under a duty to respond to this report within 56 days of the date of this report, namely by 22nd April 2026. I, the coroner, may extend the period.</p> <p>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.</p>
8	<p>COPIES and PUBLICATION</p> <p>I have sent a copy of my report to the Chief Coroner and to the following Interested Persons Wanda Moran; Kerry Hampton;. I am also sending a copy to NHS England and equivalent organisations in the other countries of the United Kingdom.</p> <p>I am also under a duty to send the Chief Coroner a copy of your response.</p> <p>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.</p>
9	<p>25th February 2026</p> 