



Regulation 28: REPORT TO PREVENT FUTURE DEATHS

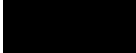
NOTE: This form is to be used **after** an inquest.

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| | <p>REGULATION 28 REPORT TO PREVENT DEATHS</p> <p>THIS REPORT IS BEING SENT TO:</p> <ol style="list-style-type: none">1. The Care Bureau2. West Northants Council3. CQC |
| 1 | <p>CORONER</p> <p>I am Hassan Shah, Assistant Coroner for the coroner area of Northamptonshire.</p> |
| 2 | <p>CORONER'S LEGAL POWERS</p> <p>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.</p> |
| 3 | <p>INVESTIGATION and INQUEST</p> <p>On 04 October 2024 I commenced an investigation into the death of Mr John Hay aged 85. The investigation concluded at the end of the inquest on 31 March 2026. The conclusion of the inquest was that:</p> <p>Mr John Hay died 2 October 2024 at Cynthia Spencer Hospice, Northampton, as a result of an unwitnessed fall at home which caused a head injury.</p> |
| 4 | <p>CIRCUMSTANCES OF THE DEATH</p> <p>Mr Hay lived alone in his own home but was receiving domiciliary care in the form of 3 daily visits from non-nursing carers. He had ischemic heart disease and atrial fibrillation. As a consequence, he was prescribed anti-coagulant medication, important in the context of a fall as it can make any haematoma more extensive. In 2017 fragile fractures were identified and a diagnosis of osteoporosis was made. In 2021, he was diagnosed with dementia. In mid-August 2024, Mr Hay suffered a fall at home with a long lie, described by his GP as a "non-specific fall attributed to old age". A safeguarding referral was made, carers were engaged and a Care Plan was done on 18 September 2024, which included a risk assessment. In relation to blood thinners, the assessment states "if client has heavy bleeding, carers to ring 999 immediately and then phone office / on call".</p> <p>Around 6 weeks after the first fall, on 26 September 2024, Mr Hay suffered a fall at home. When his carer visited at 10.34am, Mr Hay was found sitting in his chair and declined paramedics – Mr Hay's son was not consulted or notified about this decision. No concerns were documented by the carer at the time of the lunchtime visit. At the time of the third visit at 5.55pm, Mr Hay was found on the floor. The carer called his supervisor who in turn called Mr Hay's son – no calls were made to 111 or 999. Mr Hay's son arrived and called paramedics at 7.15pm. Mr Hay was conveyed to hospital. CT imaging revealed an acute right frontal, parietal and temporal subdural bleed with a maximum depth of 7mm (described as shallow). Sadly, Mr Hay became more unstable and sadly passed away on 2 October 2024. In the opinion of the Consultant Emergency Physician, it is unlikely that Mr Hay would have survived his injuries even if he had presented at hospital 12 hours earlier – his injuries were not amenable to emergency surgery.</p> |



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| | <p>The care team's medication charts for 26 September 2024 reveal that two items prescribed were "missing", presumed run out – Adcal and Esure Compact.</p> <p>The medical cause of death was:-</p> <p>1A - Subdural haemorrhage 1B - Fall 2 - Ischemic heart disease, atrial fibrillation</p> <p>A narrative conclusion was given as follows - Mr John Hay died 2 October 2024 at Cynthia Spencer Hospice, Northampton, as a result of an unwitnessed fall at home which caused a head injury.</p> |
| 5 | <p>CORONER'S CONCERNS</p> <p>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.</p> <p>The MATTERS OF CONCERN are as follows: (brief summary of matters of concern)</p> <ol style="list-style-type: none">1. The Risk Assessment in the Care Plan is neither completed nor reviewed with nursing or medical input, but includes, amongst other things, actions to be taken when a person is on blood thinners. In the present case, the only scenario covered was in relation to a person who has "heavy bleeding". The obligation to complete the risk assessment and determine actions falls upon the care team, none of whom have any medical training, aside from basic first aid.2. The process/system for escalation to get medical input was unclear. In the current case, it was accepted with the benefit of hindsight that when a frail elderly person on blood thinners suffers a fall, a medical assessment should probably be done. However, after the morning visit, it was Mr Hay himself who made the decision (despite having suffered a fall and having a diagnosis of dementia) without input from his family. At the time of the evening visit, the care team contacted the son for a decision rather than simply assessing the situation and making a decision.3. The process/system by which missing or spent medication is actioned was unclear. In the current case, Mr Hay's son was responsible for ordering medication. However, the system by which the care team would notify him was unclear. <p>The three concerns raised above did not cause or contribute to Mr Hay's death, but they might in other cases.</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/or your organisation) have the power to take such action.</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 29 May 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> |



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| | <p>I have sent a copy of my report to the Chief Coroner and to the following Interested Persons:-</p> <p>Son of deceased</p> <p>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.</p> <p>I may also send a copy of your response to any person who I believe may find it useful or of interest.</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.</p> <p>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 | Dated: 31 March 2026  Mr Hassan Shah Assistant Coroner for Northamptonshire |