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. The Secretary of State for Health** **2.** **3.** **4.** **5.** **6.** **7.** **8.** **9.** **10.**
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 23rd December 2025, I commenced an investigation into the death of Kenneth John Morris, formerly known as Kenneth John Pratt, age 78 years. The investigation concluded at the end of the inquest on 13th April 2026. The conclusion of the inquest was: ACCIDENT
4	**CIRCUMSTANCES OF THE DEATH** In the last eighteen months of his life, Kenneth Morris was losing weight unintentionally and was becoming frail. He was also prone to falling. Following admission to hospital in October 2025, he was diagnosed with bladder cancer. Following discharge from this and another admission in November 2025, his condition deteriorated, and he was readmitted to Hull Royal Infirmary on the 8th December 2025 with a working diagnosis of hypoactive delirium secondary to sepsis of unknown origin, malnutrition and frailty. He was judged to be at high risk of falling. On the 9th December 2025, he had an unwitnessed fall on the ward which was not associated with traumatic brain injury. He

	had a second fall on the ward on the 10th December 2025 which was complicated by intracranial haemorrhage, contusional damage to the brain and early post traumatic epilepsy that resulted in his death at 04:09hours on the 10th December 2025. After his first fall, he should have received one to one nursing care and observation and had he done so, he would not have fallen, sustained a traumatic brain injury and died on the 10th December 2025 at Hull Royal Infirmary.
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. – This gentleman should have received one to one nursing care but due to a combination of understaffing and more pressing cases on the ward, he did not receive such care. Evidence was heard that had he received such care he would not have fallen and died. Evidence was also heard that within the Hull Trust and probably throughout the NHS, resources are critically stretched and whilst improvements are being proposed, I believe that the current situation makes it probable that similar deaths will occur.
6	**ACTION SHOULD BE TAKEN** In my opinion action should be taken to prevent future deaths and I believe you and your department has the power to take such action, possibly by reviewing funding and staffing numbers within the NHS at large.
7	**YOUR RESPONSE** You are under a duty to respond to this report within 56 days of the date of this report, namely by 19th June 2026, but 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 [redacted] (Daughter); Hull University Teaching Hospitals NHS Trust. 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. She may send a copy of this report to any person whom she 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	**24th April 2026**