	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO:** **1. Yorkshire Ambulance Service NHS Trust** **2. NHS Pathways** **I am also sending this to the family of Christine Clegg and HC – One The Kind Care Company (Kesteven Grange Care Home Hull).**
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 24th June 2025 an inquest was opened and adjourned into the death of Christine Joan Clegg aged 79years. The investigation concluded at the end of the inquest on 16th March 2026, the conclusion of the inquest was accidental death. Mrs Clegg died at Hull Royal Infirmary on 19th June 2025 following admission for an unwitnessed fall at the care home where she lived. Upon admission Mrs Clegg was diagnosed with was diagnosed with traumatic subdural hematoma and sadly succumbed to her injuries in hospital. The cause of death was 1a. Traumatic subdural haemorrhage 1b. Unwitnessed fall 2. Dementia
4	**CIRCUMSTANCES OF THE DEATH** Mrs Clegg died at Hull Royal Infirmary following admission for an unwitnessed fall at her care home. The circumstances of the fall were Mrs Clegg was discovered on the floor of her bedroom by a carer. The alarm was raised and a call to NHS 111 was made, During this call the staff member told the 111 operator Mrs Clegg had "put herself on the floor" and had a "bump" to her head. The situation appears to have down played and information passed to the operator which was biased information suggesting Mrs Clegg had placed herself on the floor when in fact she had fallen from a bed and which caused the wrong script to be

	followed by the operator. The head injury was actively bleeding and the script which should have been followed was that of head injury but instead because of the information given by the care staff the script which was followed was the scratches grazes or minor wounds pathway. This resulted in a different outcome to the one the correct pathway was likely to recommend which was to seek clinician input. Even if all answers within the Head, Facial or Neck Injury Pathway are answered negatively the outcome will be to 'speak to a clinician for home management advice' whereas the use of this pathway for 'Scratches, Grazes or Minor wounds' results in a disposition of 'Symptom Management Advice'. In the case of Mrs Clegg the call resulted in information (basic first aid advice) that is provided by the operator to the caller and the call ends with no clinical input. Mrs Clegg had suffered a traumatic brain injury in this fall and subsequently deteriorated over the next few days which led to her admission to Hull Royal Infirmary where she sadly died.
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) The NHS 111 script for scratches grazes or minor wounds is available for head injuries but can lead to a non clinical outcome and basic first aid advice being given. The fact is, however, either a scratch, graze or nick above the neck indicates that either has been a head injury of some degree or other and so the script which should correctly be followed is the head injury pathway. If injuries above the neck were excluded from the scratches grazes and nicks pathway then the possibility of basic first aid advice being given is eliminated as all head injury answered result in clinician advice being sought. (2)
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 22nd July 2026. 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 Christine Joan Clegg and HC-One The Kind Care Company/Kesteven Grange. 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]** ***27th April 2026 Sally Robinson, Assistant Coroner***