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 England** **3. NHS Humber and North Yorkshire ICB** **I am also sending this to the family of Mrs Pauline Margerat Bradley.**
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 27th November 2025 an inquest was opened and adjourned into the death of Pauline Margerat Bradley aged 90 years. The investigation concluded at the end of the inquest on 24th April 2026, the conclusion of the inquest was accidental death. Mrs Bradley died at Hull Royal Infirmary following admission for an unwitnessed fall at home. Upon admission Mrs Bradley was diagnosed with community acquired pneumonia, fractures and multiple bleeds in her brain. Over the course of her admission she tested positive for RSV and was transferred to Ward H90 were she was put into a cubicle as she was deemed to be an infection risk for others. There had been a falls risk assessment and Mrs Bradley was a Level 2 risk of falls. This meant hourly observations. Mrs Bradley's family were engaged with staff throughout but were not told upon admission to Ward H90 that they could stay and provide one to one observations themselves. On the 24th October at around shift change between 19:30hrs and 20:30hrs Mrs Bradley suffered a further fall this time in her cubicle. She was discovered by a staff nurse a short while after handover. A further scan was requested and new bleeds were shown ion the scan. Because of this fall Mrs Bradley was reassessed as Level 3 falls risk and one to one supervision was requested. Family were told of this fall but not that Mrs Bradley had suffered a period of unconsciousness. Family ultimately provided round the clock support at

	hospital until Mrs Bradley's death on 8th November 2025. Her medical cause of death was recorded as: 1a. Aspiration pneumonia and intercerebral haemorrhage (joint case) 1b. Falls
4	**CIRCUMSTANCES OF THE DEATH** Mrs Bradley died at Hull Royal Infirmary following admission for an unwitnessed fall at home. Upon admission Mrs Bradley was diagnosed with community acquired pneumonia, fractures and multiple bleeds in her brain. Over the course of her admission she tested positive for RSV and was transferred to Ward 90 were she was put into a cubicle as she was deemed to be an infection risk for others. There had been a falls risk assessment and Mrs Bradley was a Level 2 risk of falls. This meant hourly observations. Mrs Bradley's family were engaged with staff throughout but were not told upon admission to Ward 90 that they could stay and provide one to one support themselves should they wish. On the 24th October at around shift change between 19:30hrs and 20:30hrs Mrs Bradley suffered a further fall this time in her cubicle. She was discovered by a staff nurse a short while after handover. A further scan was requested and new bleeds were shown on the scan. Because of this fall Mrs Bradley was reassessed

	as Level 3 falls risk and one to one supervision was requested. Family were told of this fall but not that Mrs Bradley had suffered a period of unconsciousness. Family ultimately provided round the clock support at hospital until Mrs Bradley's death on 8th November 2025. The family at inquest raised concerns abouit5 communication with families on the ward and said that they felt it could be better. Mrs Bradley was not found straight away following her fall as there was no alert system in the cubicle in the form of bed movement sensor or falls mat as the falls mats available on the ward were in use with other patients. .
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 family were not told that they were welcome to provide support to Mrs Bradley on the ward initially. Whilst it is acknowledged that not all

	patients have family or friends who are able to help the family of Mrs Bradley felt that communication could have been improved on the ward which may have meant that Mtrs Bradley would not have fallen on the ward as family would have been with her. (2) The cubicles on Ward H90 Hull Royal Infirmary do not all have falls mats or sensors and whilst is acknowledged that these are not always appropriate in hospital settings it may be desirable that there are enough so that one may be used. (3)Although staffing was optimal on the evening of 24th October 2025 at the time of Mrs Bradley's fall the staff were engaged in hand over leaving the cubicles unmonitored for a period of time.
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 21st August 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 Pauline Margerat Bradley. 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]** ***24th June 2026 Sally Robinson, Assistant Coroner***