	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO:** **1.Westfield Residential Home Willerby East Riding of Yorkshire** **2. Care Quality Commission** **I am also sending this to the family of Susan Dale.**
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 1st May 2026 an inquest was opened and adjourned into the death of Susan Dale aged 78years. The investigation concluded at the end of the inquest on 25th June 2026, the conclusion of the inquest was accidental death. Mrs Dalew dies at Hulk Royal Infirmary after being admitted from Westfield Residential Home Willerby East Riding of Yorkshire. Mrs Dale had suffered fall at the home the day previously. She had had several falls in the home in the preceding weeks and some of these resulted in head injury. Mrs Dale was found to have suffered bilateral subdural hematomas and was for conservative management. Mrs Dale had a diagnosis of dementia and had recurrent UTIs and had presented at hospital with inflammatory markers suggestive of infection although of unknown ethology. Antibiotics were started but Mrs Dale's condition failed to improve and the decision was for end of life care. Mrs Dale sadly died on 18th April 2026. The case of death given by the hospital doctor was: 1a Subdural haematoma 2. Dementia and frailty. Fall was added at inquest at 1b but it was not possible to say which fall had caused the subdural haematoma or indeed if the last fall exacerbated an already developing clinical situation.

4	**CIRCUMSTANCES OF THE DEATH** Mrs Dale was a resident at Westfields Residential Home and had been for a number of months. She required help with eating drinking and personal care. On the morning of 8th April 2026 Mrs Dale was being assisted with her morning routine by a care assistant in the home. As the care assistant was helping Mrs Dale into her wheel chair Mrs Dale became unsteady and fell to the floor. The statement of the care assistant does not detail her injuries but the accident report says Mrs Dale banged her hand. A l retrospective entry on the advanced care cloud system details a hearsay report of the fall and states that Mrs Dale had a small graze to the back of her head where she had banged it. The statement says the care assistant came on shift at 0700 and is silent on the time of the fall. The advanced care cloud entry says the tome of the incident was 11.56hrs and the accident report which states Mrs Dale banged her hand and makes no mention of her head,. The accident report states the fall occurred at 09.00hrs. Following the fall the care assistant went to call the GP. 111 was not called. Some hours later a different staff member noticed Mrs Dale was deteriorating and she appear to be possibly having a stroke, An ambulance was called and Mrs Dale was taken to hospital and did not return to the home before she sadly died..
5	**<u>CORONER'S CONCERNS</u>** 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 record keeping in the home appeasers to be inaccurate and inconsistent (2) The falls policy of the home states that there are number of scenarios to consider before lifting a resident for the floor and states that the resident should not be moved until clinical assistance arrive. One such situation is if head, neck, back or hip injury is suspected. The incident log on advanced care cloud states there was ahead injury yet Mrs Dale was moved and no clinician saw her until she worsened and an ambulance was called. Inaccuracies in reporting can lead to missed opportunities to provide care and inaccurate time recording of incidents can lead to the accurate appraisal of the developing clinic picture being made more difficult which in turn would lead to a delay in medical assistance being sought. This could lead to resident safety being compromised and deaths occurring. (3) The senior care worker who came on shift later that day said she did not receive any hand over from the staff going off shift. This is a

	concern as observations need to be carried out when someone has fallen and banged their head and a handover would detail such incidents and whether there are any concerns with residents.
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 Susan Dale and the Manager of Westfield Residential Home Willerby East Riding of Yorkshire. 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]** ***26th June 2026 Sally Robinson, Assistant Coroner***