



HM CORONERS COURT

IN THE MATTER OF THE INQUEST

TOUCHING THE DEATH OF PAMELA MARGARET HINDLEY

	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS
1	CORONER I am Guy Davies, His Majesty's Assistant Coroner for Cornwall & the Isles of Scilly.
2	DATE OF REPORT 10 August 2026
3	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.
4	THIS REPORT IS BEING SENT TO Secretary of State for Health and Social Care You are under a duty to respond to this report within 56 days of the date of this report, namely by 5 October 2026. I, the coroner, may extend the period if an appropriate application is made.
5	YOUR RESPONSE 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. I have a duty to send a copy of your response to the Chief Coroner. In accordance with the Chief Coroner's Publication Policy, you should send me any representations regarding publication of your response. These representations should be made at the same time as the response is provided. I will pass any representations received to the Chief Coroner for a decision.

	Please note any links to webpages included in the response will not be checked for sensitive information prior to publication, as the information is already online. The names of those who do not respond to PFD reports are regularly published on the Chief Coroner's webpages Non-responses to Prevention of Future Death (PFD) reports - Courts and Tribunals Judiciary.
6	SUMMARY OF CORONER'S CONCERN Inadequate social care provision, whether commissioned by NHS or social services, leading to a risk of future deaths.
7	ACTION SHOULD BE TAKEN 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.
8	INVESTIGATION and INQUEST On 2 December 2024 I commenced an investigation into the death of 80-year-old Pamela. The investigation concluded at the end of the inquest on 1 July 2026. The medical cause of death was established on the evidence as follows: <i>1a Left Subdural Haematoma</i> <i>1b Fall</i> <i>2 Frailty of Old Age, Chronic eosinophilic leukaemia</i> The four questions - who, when, where and how – were answered as follows: <i>Pamela Margaret HINDLEY died on 23 November 2024 at Royal Cornwall Hospital Treliske Truro from trauma consistent with an unwitnessed fall at her home contributed to by frailty of old age and leukaemia. The unwitnessed fall followed a discharge from hospital one week earlier in circumstances in which Pamela's mobility was reduced to mobilising with a frame. The community services had not been able to provide the necessary aids and adaptations to Pamela's home before her discharge, and before she suffered her fatal fall. Pamela was not able to give an account of why she fell and it is not possible to determine whether the absence of aids and adaptations caused or contributed to her fatal fall.</i> My conclusion as to the death was as follows: <i>Accident</i>
9	CIRCUMSTANCES OF THE DEATH Pamela was frail and a falls risk with limited mobility following a discharge from Royal Cornwall Hospital Treliske Truro (RCHT) on 15 November 2024. On discharge Pamela had been reduced to mobilising by way of zimmer frame. The discharge took place against a background of a planned rapid discharge event at RCHT in which the hospital wards and community services were required to work together to reach certain targets of numbers of patients discharged. These targets were well above the usual rate of discharges and created significant pressure on ward staff and community services. Therapy paperwork was not completed during the preparation for the rapid discharge of

	Pamela. This resulted in a missed opportunity to alert community services to the need to conduct an assessment of the safety of Pamela's home environment. The home assessment did not take place until after Pamela's discharge. There was then a delay in arranging the necessary adaptations to Pamela's home. These included the installation of grab rails around the property and the uncluttering of the bedroom which contained a double bed which needed to be moved and replaced with a single bed in order to ease restricted movement in that room. One week after discharge and just before the adaptations were to be implemented Pamela suffered an unwitnessed fall in the bedroom and sustained a catastrophic head injury. Pamela did not regain consciousness before dying. It was not possible to determine the reason for the fall and whether the absence adaptations contributed. It was found that with sufficient notice before discharge, these adaptations could have been implemented.
10	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. – Rapid discharge events put significant pressure on hospital staff and community services and increases the risk of patients being discharged without sufficient care provision including necessary aids and adaptations to the home environment necessary to ensure the safety of those discharged from hospital. The root cause of the need for the rapid discharge event was inadequate social care provision, this being an ongoing situation. The court found significant numbers of patients in hospital who are medically fit for discharge and with no reason to reside in hospital (NCTR) but cannot be discharged due to lack of available social care provision (whether commissioned by social services or NHS). At times up to 20% of patients in RCHT have NCTR status. This creates pressure on bed availability on hospital wards and impedes patient flow through the hospital. This in turn leads to other issues such as crowding and corridor care in the emergency department, patients in ambulances, and ambulance delays in the community. The court noted investigations in 2022 and 2023 by South West Ambulance Trust (SWAST) and the Healthcare Safety Investigation Branch (HSIB) which found a direct link between ambulance delays and inadequate social care provision. The court noted the SWAST systems report which found... <i>"....there is a direct link between patients waiting in the hospital for discharge to social care and patients being cared for inside ambulances and Emergency Departments."</i>
11	COPIES AND PUBLICATION OF THIS REPORT I have a duty to send a copy of my report to every Interested Person who in my opinion should receive it. I also may send a copy of the report to any other person who I believe may find it useful or of interest.

	I can confirm I have sent the report to: 1. Pamela's family 2. The family of Philip Peel Cardew (a recent Inquest found that Philip died after an ambulance delay) 3. RCHT 4. SWAST 5. Disability Cornwall 6. The Community Helping All of Society Group Cornwall (CHAOS) I also have a duty to send a copy of the report to the Chief Coroner. You may make representations to me, the coroner, about the publication of the contents of this report in line with Chief Coroner's PFD Publication Policy (2026). Any representations will be sent to the Chief Coroner alongside the report. Please refer to box 4 above for additional information relating to the publication of reports and responses.
	SIGNATURE HMC Guy Davies