OFFICE OF HER MAJESTY'S CORONER
DERBY& DERBYSHIRE CORONER'S AREA

REGULATION 28: REPORT TO PREVENT FUTURE DEATHS (1)

	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO:** **1. Chief Executive Chesterfield Royal Hospital**
1	**CORONER** I am Robert W Hunter, senior coroner, for the coroner area of Derby and Derbyshire.
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** On18th October 2013 I commenced an investigation into the death of William Leonard Beckwith, 91 years old. The investigation concluded at the end of the inquest on 10th April 2014. The conclusion of the inquest was one of **Accidental Death.** The medical Cause of Death being: **1a. Gastro-intestinal tract haemorrhage.** **1b. Duodenal Ulcer** **II. Cervical spine fracture (treated), Acute stress ulceration, Bronchopneumonia**
4	**CIRCUMSTANCES OF THE DEATH** **On the 13th September 2013 William Leonard Beckwith sustained a fracture to his cervical spine resulting from a fall at home. He attended the accident and emergency department of the Chesterfield Royal Hospital. Medical and Nursing staff were aware of a history of previous falls. Reduced range of movement of his cervical spine was noted at that time, however his fracture was not diagnosed and he was discharged home at 04:17 hours in the morning. He was readmitted with acute stridor on the 15th September 2013 caused by a blood clot from the cervical fracture compressing his wind pipe. Despite management in intensive care and on the ward he continued to deteriorate and died on the 11th October 2013. From the evidence heard at inquest, on the balance of probabilities, earlier diagnosis of the fracture would not have affected the outcome.**

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. – A 91 year old patient, with a history of falls and who had attended A&E due to a fall was discharged home at 04:17 hours in the early morning to his elderly wife. There was no formal assessment as to his abilities, the home environment or his wife's abilities to look after him. No consideration was given to post discharge planning or assessment of needs such as district nurse or social care follow up. The Department, at that time, did not have in place any formal policy or procedure for risk assessing the safety of discharging a frail, elderly patient to home in the early hours of the morning.
6	**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.
7	**YOUR RESPONSE** You are under a duty to respond to this report within 56 days of the date of this report, namely by Monday 4th August 2014. 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] Mr Beckwith's son. 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	**9th June 2014** **Dr Robert W Hunter** **Senior Coroner**