REGULATION 28: REPORT TO PREVENT FUTURE DEATHS

	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO:** 1. **The Chief Executive, Chesterfield Royal Hospital** 2. [redacted] 3. **Ashgate House Nursing Home** 4. [redacted]
1	**CORONER** I am Peter Nieto Assistant 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. https://www.legislation.gov.uk/ukpga/2009/25/contents http://www.legislation.gov.uk/uksi/2013/1629/contents/made
3	**INVESTIGATION and INQUEST** On 15 June 2017 I commenced an investigation into the death of Barbara Christine Sturgess (dob: 15 December 1932; dod: 8 June 2017). The investigation concluded at the end of the inquest on 20 September 2017. The conclusion of the inquest was: - - Medical cause of death: - 1a Bronchopneumonia 1b Cervical spinal fracture - Summary of circumstances: - Died on 8 June 2017 at Ashgate Nursing Home due to bronchopneumonia contributed to by a cervical spinal fracture sustained during a fall at the nursing home on 20 May 2017. - The conclusion of the inquest was that the death was an accident.
	CIRCUMSTANCES OF THE DEATH Barbara Christine Sturgess moved to Ashgate Nursing Home from a residential care home due to an increase in her needs. She suffered from a number of conditions including advanced dementia. She needed support and supervision in all aspects of her daily care and due to her confusion she could be resistive to care. Although she was able to mobilise around the nursing home unaided she was assessed as at high risk of falls due to her profile and conditions, including her dementia. She sustained a fall on 20 May 2017 and on attendance at hospital a cervical spinal fracture was diagnosed and she returned to the nursing home. She died on 8 June 2017 of bronchopneumonia which, on the evidence, resulted from the cervical spinal fracture sustained on 20 May 2017.

5	**CORONER'S CONCERNS** During the course of the inquest the evidence revealed a matter giving rise to concern. In my opinion there is a risk that future deaths could occur unless action is taken. In the circumstances it is my statutory duty to report to you. The **MATTER OF CONCERN** is as follows. – The Chesterfield Royal Hospital did not inform the nursing home or the GP practice that Barbara Christine Sturgess had sustained a cervical spinal fracture nor of any necessary measures in her care and treatment. Her daughter attended a fracture clinic appointment with her on 24 May 2017 where a Doctor told the daughter that a fracture had been sustained and that care should be exercised in her management on account of the fracture. It was only on 26 May 2017, as a result of enquiries by the nursing home, that formal confirmation of the fracture was provided by the hospital. Although there was no evidence that the failure of the hospital to properly confirm and advise on the fracture was a factor in Barbara Christine Sturgess's death this did have the potential to adversely affect her wellbeing. Very importantly if there were to be further similar failings in communication it could be that for some patients this could be a contributory factor in death.
6	**ACTION SHOULD BE TAKEN** In my opinion action should be taken to prevent future deaths and I believe you and 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, which is by 16 November 2017. 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: - 1. [redacted] (Barbara Christine Sturgess's daughter) 2. Ashgate House Nursing Home (the nursing home where Barbara Christine Sturgess resided) I have also sent it to [redacted] (GP for Barbara Christine Sturgess – The Surgery, Wheatbridge Road, Chesterfield) who may find it useful or of interest. 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	21 September 2017  Peter Nieto Assistant Coroner