Mrs Sarah Louise Slater
Assistant Coroner for South Yorkshire (East District)

	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO: Mr Richard Parker, Chief Executive, Doncaster and Bassetlaw Teaching Hospital and Mr Matt Hancock Secretary of State for Heath and Social Care**
1	**CORONER** I am Mrs Sarah Louise Slater, Assistant Coroner for South Yorkshire (East District)
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. http://www.legislation.gov.uk/ukpga/2009/25/schedule/5/paragraph/7 http://www.legislation.gov.uk/uksi/2013/1629/part/7/made
3	**INVESTIGATION and INQUEST** On 13/12/2017 I commenced an investigation into the death of Roy Burgess, 87. The investigation concluded at the end of the inquest on Wednesday 21 November 2018. The conclusion of the inquest was a Narrative conclusion as follows: Mr Burgess underwent surgery at Doncaster Royal Infirmary on the 3rd December 2017 to repair a fracture to his left neck of femur which he sustained in fall at his home on the 1st December 2017. Post operatively, there were missed opportunities to identify and escalate Mr Burgess's deteriorating condition prior to his death. However it is unlikely that any such interventions would have altered the outcome.
4	**CIRCUMSTANCES OF THE DEATH** Mr Burgess was taken to Bassetlaw Hospital on the 1st December 2017 having suffered a fall in the garden of his home. He was transferred to Doncaster Royal Infirmary on the 2nd December 2017 and he remained there until his death. Cause of death : I (a) Left femoral fracture (treated) and Ischaemic heart disease (b) Coronary artery atheroma II Advanced age
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.

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	The **MATTERS OF CONCERN** are as follows. – (1) The hospital Early Warning System used to identify and escalate a deteriorating patient was not adhered to. This allowed missed opportunities for Mr Burgess's care to receive Senior Medical reviews which could have altered his management. (2) Inadequate record keeping by clinician within the Clinical notes. There were numerous examples of care having been escalated by nursing staff to doctors but no record of their input following this escalation was entered in the notes, e.g. on 4th December 2017, Mr Burgess's care was escalated between 11:40 hours and 16:30 hours on at least 5 occasions and no entries were placed in his clinical records. This could have had a detrimental effect on his care and if this practice continues it will potentially affect other patients. (3) Finally, untimed dictated notes of ward rounds, were then entered into the records in a non-chronological order, which was unhelpful and potentially misleading
6	**ACTION SHOULD BE TAKEN** In my opinion action should be taken to prevent future deaths and I believe you 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 **15 January 2019**. 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] I have also sent it to [redacted] (Yorkshire Ambulance Service) 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	Dated 21 November 2018 Signature Assistant Coroner for South Yorkshire (East District)