REGULATION 28: REPORT TO PREVENT FUTURE DEATHS

	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO:** **1. Chief Executive Officer, LAMBTON HOUSE LTD**
1	**CORONER** I am Jeremy Chipperfield, senior coroner for the coroner area of Durham and Darlington
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/schedule/5/enacted https://www.legislation.gov.uk/uksi/2013/1629/regulation/28/made https://www.legislation.gov.uk/uksi/2013/1629/regulation/29/made
3	**INVESTIGATION and INQUEST** On Second September 2022 I commenced an investigation into the death of Sylvia GIBSON, aged 96. The investigation concluded at the end of the inquest on 27th October 2022. I found that the deceased died as a result of natural causes to which accidental injuries contributed.
4	**CIRCUMSTANCES OF THE DEATH** Sylvia sustained an unwitnessed fall in the early hours of 17th August 2022 thereby sustaining injuries. These injuries were not reported to the attending medical practitioner.
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 could occur unless action is taken. In the circumstances it is my statutory duty to report to you. The **MATTERS OF CONCERN** are as follows. – Although staff at Lambton House Care Home were aware of her fall in the early hours of 17th August, and this information was handed over to other staff, the same information was not conveyed to the doctor who visited Sylvia (being "not her usual self") at around lunchtime that day. **It appears that no systems were in place to ensure that important information is conveyed to healthcare professionals**. Evidence does not suggest that this communications failure contributed to Sylvia's death.
6	**ACTION SHOULD BE TAKEN** In my opinion action should be taken to prevent future deaths and I believe you 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 22 December 2022. 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 I am also under a duty to send a copy of your response to the Chief Coroner and all interested persons who in my opinion should receive it. I may also send a copy of your response to any other person who I believe may find it useful or of interest. 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.
9	 **Jeremy CHIPPERFIELD** **27 October 2022**