Regulation 28: REPORT TO PREVENT FUTURE DEATHS

NOTE: This form is to be used **after** an inquest.

	REGULATION 28 REPORT TO PREVENT DEATHS **THIS REPORT IS BEING SENT TO:** **East Sussex Healthcare NHS Trust**
1	**CORONER** I am Rachel REDMAN, Assistant Coroner for the coroner area of East Sussex Coroners Service
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** On 29.05.2024 I commenced an investigation into the death of David Joseph DUGDALE aged 58. The investigation concluded at the end of the inquest on 21.11.2025. The narrative conclusion of the inquest was that: David Dugdale was admitted to Eastbourne District General Hospital on 20.01.2024 with pneumonia and upper GI bleed. He also had undetected bilateral hip fractures. On 24.02.2024 he was transferred to Conquest Hospital where he underwent surgery but deteriorated owing to his co-morbidities and a category 4 pressure sore. He died on 19.05.2024.
4	**CIRCUMSTANCES OF THE DEATH** David was admitted to Eastbourne District General Hospital on 20.01.2024, he fell on 08.02.2024 and was diagnosed with bi-lateral neck of femur fractures on 21.02.2024. He was transferred to Conquest Hospital, Hastings where he underwent surgery on 27.02.2024, 11.03.2024 and 20.03.2024. He died on 19.05.2024, the cause of his death being: 1a Pneumonia 1b Fracture displacement of left femoral head and sacral pressure sore 2
5	**CORONER'S CONCERNS** During the course of the investigation my inquiries 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: (brief summary of matters of concern) I have the following concerns about the quality of clinical care David Dugdale received at Eastbourne District General Hospital (EDGH) and Conquest Hospital, Hastings:

	1. Poor management of David's pain. In spite of sustaining a category 2 pressure sore and bilateral hip fractures whilst an in patient at EDGH, he was only receiving oral paracetamol. Not until ambulance crew raised their concerns about his inadequate pain relief prior to their transferring him to Conquest Hospital did he receive increased and more appropriate pain relief. His carers repeatedly tried to advise nursing staff that he was in pain, but their concerns were not listened to nor acted upon. 2. David lost 3kgs in weight during the first month of his admission to EDGH. He was not eating nor drinking. There seemed to be little nutritional support available to David in the early stages of his admission causing him to lose almost 30kgs in total. 3. The pressure sore deteriorated to grade 4 during his admission which was a direct cause of his death. He was often found lying in soiled dressings with his pressure sore exposed and in pain by his visiting carers. 4. In spite of receiving a statement from ESHT regarding improvements in nursing care my concerns were not allayed.
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 March 05, 2026. 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. I have also sent it to **Woodcote (care home)** who may find it useful or of interest. 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 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 by the Chief Coroner.
9	**Dated: 08/01/2026** [redacted] **Rachel REDMAN** **Assistant Coroner for**

	East Sussex Coroners Service