MS N J MUNDY
H M CORONER
SOUTH YORKSHIRE (East District)

email: [redacted]

CORONER'S COURT AND OFFICE
CROWN COURT
COLLEGE ROAD
DONCASTER DN1 3HS

[redacted]

REGULATION 28 REPORT TO PREVENT FUTURE DEATHS

THIS REPORT IS BEING SENT TO: [redacted], Chief Executive, Doncaster Royal Infirmary

1. CORONER

I am Ms N J Mundy, Senior Coroner for South Yorkshire East

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 11 November 2024 I commenced an investigation into the death of Dennis Keith Price. The investigation concluded at the end of the inquest . The conclusion of the inquest was:

Accidental death

1a Subdural haemorrhage

1b Fall

1c

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4. CIRCUMSTANCES OF THE DEATH

This case relates to the death of Dennis Keith Price a 71 year old male who passed away on 28th October 2024 following admission to the Doncaster Royal Infirmary on the 24th October 2024 due to acute limb weakness and being unable to weight bear. On the 28 th October in the afternoon, he suffered a fall when making his way unescorted to the toilet. There was some delay in him being attended to by nurses and helped him to bed and doctor's assessment shortly after that revealed a Glasgow Coma Score of 15. The inpatient post falls review was not fully completed in that there was no indication as to whether the question with regard to head injury was 'yes' or 'no' or 'don't know'. There is no reference to Mr Price's blood thinning medication being a factor. There was no clear direction from the attending doctor as to the frequency or neurological observations which were merely stated to be that he was to be observed for two hours. Furthermore, the recorded (and deteriorating) Glasgow Coma Score triggered three escalations through the Nerve Centre System the first of which was not completed until several hours (the following morning) after the alert triggered.

As it was, between Glasgow Coma Score checks there was a catastrophic deterioration when he dropped from a score of 13 to 6 leading to Mr Price passing away later on that evening on

the 28th October from a subdural haemorrhage.

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:

1. Failure to properly complete the inpatient post fall review.
2. No clear plan for frequency of neurological observations and duration of the same and associated lack of clear direction from the attending Doctor following a fall.
3. The efficiency of the Nerve Centre system escalations in that any triggers must be followed up and properly completed on the system for the nerve centre system to be fully effective.

6. ACTION SHOULD BE TAKEN

In my opinion action should be taken to prevent future deaths and I believe you Richard Parker 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 the **10th March 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 and to the following Interested Persons [redacted]

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.

20 January 2026

Signature Ms N J Mundy, LL.B (hons)

[redacted]

for South Yorkshire East