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:** **1 Bank Close House Residential Care Home**
1	**CORONER** I am Sarah HUNTBACH, 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.
3	**INVESTIGATION and INQUEST** On 21 March 2025 I commenced an investigation into the death of Peter William THOMPSON aged 77. The investigation concluded at the end of the inquest on 13 January 2026. The conclusion of the inquest was that: Peter William Thompson was admitted into Chesterfiled Royal Hospital on 5 March 2025 with a significantly high blood sugar level and a recent history of infection, reduced food and fluid intake and refusal to take medication. He was treated for Hyperglyceamic Hyperosmoal State. Whilst he initially responded to the treatment due to the severity of his kidney damage caused by progressive deyhdration his prognosis remained poor. The day after he was admitted his bloods showed rising sodium levels and signs of acidosis. Due to his frailty and the severity of his condition intensive treatment was not recommended. He was placed on palliative care and passed away on 9 March 2025. Peter had been diagnosed with Type 2 Diabetes since 2001. This had been managed with medication. Due to his worsening health after having fallen and fractured his hip he moved into residential care at the end of 2024. At the end of February 2025 he became ill and developed a urinary tract infection. He continued to deteriorate and there were missed opportunities between 28 February 2025 and 5 March 2025 to test his blood sugar levels and identify them to be increasing. Had such tests been done by 3 March 2025 Peter would have been admitted to hospital for treatment and treatment started. The delay in admission to hospital and starting treatment has more than minimally contributed to Peter's death.
4	**CIRCUMSTANCES OF THE DEATH** Peter Thompson was diagnosed with Type 2 Diabetes in 2001. At the end of 2024 he moved into Bank House Residential Care Home because of his worsened mobility following a fall and fracturing his hip. His diabetes was controlled with medication and managing his diet. His blood sugars were regularly checked by his GP. When he moved to Bank House his GP practice changed.

	He became ill at the end of February 2025 with a urinary tract infection. He was prescribed antibiotics in solution form. His other medication was not in liquid form. He was not eating and had swallowing difficulties causing him to pool his food and medication. He started to refuse medication. His health deteriorated. His blood sugars were not tested. His illness caused a recogonised complication of Type 2 Diabetes - Hyperglyceamic Hyperosmolar State. This was due to infection causing increasing blood sugar levels. This caused kidney damage. On 5 March 2025 the Community Nurse attended for a regular review of his skin wounds and found his to be in a critical state. She called 999. The paramedics attended. They tested his blood sugars with the pin prick and found these to be significantly high. He was admitted to hospital. However, his condition was so severe he could not recover despite treatment. He died in hospital 4 days later.
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) 1. Worsening blood sugar levels in a resident with Type 2 Diabetes can be fatal. Illnesses including infection can cause the progressive condition of Hyperglycaemic Hyperosmolar State. This is what happened with Peter Thompson. No one tested his blood sugar levels until the paramedics attended on 5 March 2025. By this time his condition was so severe his prognosis was poor and he did not recover despite treatment. I heard evidence that the earlier treatment is started the better the prognosis. I heard evidence from members of the Ageing Well Team and the Community Nurse that there was an expectation that Care Home staff were carrying out the blood sugar pin prick test. The former manager of the home said that Care Home staff do not do this and do not have the equipment to do this. This test is not complex. It is a test that a resident or a carer would do in their own home. It would form part of a baseline observation for a Type 2 Diabetic patinet who was ill and assist with decision on need to escalate. The continued absence of this test being done by care home staff gives cause for concern that there is a risk that a future death could occur. 2. I heard evidence from the former manager that handovers between shifts do not take place. That staff should look in an individual residents' records. Records do not provide a complete picture of a residents condition and in particular details of staff's ongoing concerns. The priority of the continuing concern about Peter's deterioration does not appear from the records to have been handed over between shifts. To not have a formal handover at the end and start of a shift gives cause for concern that there is a risk to future death. That delays are caused in escalating a resident's condition.
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 10, 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] **Ageing Well Team** I have also sent it to 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: 13/01/2026** [redacted] **Sarah HUNTBACH** **Assistant Coroner for** **Derby and Derbyshire**