IN THE DERBY CORONER'S COURT
IN THE MATTER OF:

Inquest Touching the Death of Donald Martin
A Regulation 28 Report – Action to Prevent Future Deaths

1	**THIS REPORT IS BEING SENT TO:** Cecilia Banjoko RCN Legal Services Lyndon House 58-62 Hagley Road Birmingham B16 8PE Lindsey Foster General Manager The New Lodge Nursing Home 114 Western Road Mickleover Derby Derbyshire DE3 9GR
2	**CORONER** Miss Anna Crawford, HM Assistant Coroner for Derby and Derbyshire
3	**CORONER'S LEGAL POWERS** I make this report under paragraph 7(1) of Schedule 5 to The Coroners and Justice Act 2009.
4	**INVESTIGATION and INQUEST** The investigation into the death of **Mr Martin** was commenced on 21 January 2016 and the inquest concluded on 14 February 2018. The cause of death was: 1a. Acute on chronic respiratory failure. 1b. Smoking-related Chronic Obstructive Pulmonary Disease exacerbated by aspiration of foreign material. The conclusion was 'Natural Causes'.

5	**CIRCUMSTANCES OF THE DEATH** Mr Martin was a 96 year old gentleman and a resident at Langdale Heights Nursing Home. He suffered from Chronic Obstructive Pulmonary Disease and was on long-term oxygen treatment. On 14 January 2016 he was observed by the nursing and care staff to be struggling to breathe. The Nurse in Charge contacted the ambulance service and Mr Martin was pronounced deceased shortly after their arrival. The court found that there had been a number of non-causative deficiencies in the emergency response provided by the Nurse in Charge prior to the arrival of the ambulance service.
6	**CORONER'S CONCERNS** Nurse Cecilia Banjoko was the nurse in charge on 14 January 2016. During the course of the inquest she gave evidence that she no longer works at Langdale Heights Nursing Home and is now a nurse at The New Lodge Nursing Home in Mickleover, Derby. She gave evidence that since Mr Martin's death she had attended and completed practical training in relation to basic life support and cardio-pulmonary resuscitation (CPR). However, she also gave evidence that (i) she did not know then and still did not know why the ambulance controller had asked her to move Mr Martin from his bed to the floor prior to the arrival of the ambulance crew and (ii) she did not know how to deflate a patient's mattress at the time of Mr Martin's death and was still unaware of how to do so. The **MATTER OF CONCERN** is: I am concerned that Nurse Banjoko: (i) may not understand why or when it appropriate to carry out CPR on a flat service; (ii) does not know how to deflate patient mattresses in the event of an emergency.
7	**ACTION SHOULD BE TAKEN** In my opinion action should be taken to prevent future deaths and I believe that the people listed in paragraph one above have the power to take such action.

8	**YOUR RESPONSE** You are under a duty to respond to this report within 56 days of its date; I may extend that period on request. Your response must contain details of action taken or proposed to be taken, setting out the timetable for such action. Otherwise you must explain why no action is proposed.
9	**COPIES** I have sent a copy of this report to the following: 1. Lorna Smith 2. Langdale Heights Nursing Home 3. Nursing and Midwifery Council 4. Care Quality Commission 5. The Chief Coroner
10	**Signed:** **ANNA CRAWFORD** **DATED this 28th day of March 2018**