Her Majesty's Coroner
Staffordshire (South) Coroner's Jurisdiction

Date: 24 December 2019

Case: 1648196

REGULATION 28 REPORT TO PREVENT FUTURE DEATHS

THIS REPORT IS BEING SENT TO: Hunters Lodge Care Home Hollybush Lane Codsall WV8 2AT

1. CORONER'S LEGAL POWERS

I am Andrew A Haigh Senior Coroner for Staffordshire South

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.

2. INVESTIGATION and INQUEST

On 23 October 2019 I commenced an investigation into the death of Keith Graham WHETTON. The investigation concluded at the end of the inquest. The conclusion of the inquest was

An elderly man in declining health who fell in a care home.

The cause of death was:

1a End Stage Dementia and frailty

II Fracture right neck of femur

3. CIRCUMSTANCES OF THE DEATH

Keith had an unwitnessed fall in his room at Hunters Lodge Care Facility on the 07.09.19. [redacted] attended as part of his Monday morning visit to the care home on the 09.09.19. He then sent Keith to New Cross Hospital Wolverhampton on the 09.09.19, where he was found to have a fractured right hip. He was then operated on and had a hemiarthroplasty and remained in hospital, until he was discharged back to the Care home on the 27.09.19. Sadly he continued to deteriorate and died at the home on the 05.10.19

4. 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.

5. The MATTERS OF CONCERN are as follows. –

You should already be aware of the concerns in this matter. Even if medical attention was not sought for Keith on 7th September it clearly should have been requested on 8th September. We hope that this has now been taken on board by your home. Additionally, family members felt that they should have been informed earlier about Keith's fall and I wonder if lessons have been learned here as well.

6. ACTION SHOULD BE TAKEN

In my opinion action should be taken to prevent future deaths and I believe you 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 18.2.2020. 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 – the family of the deceased.

I have also sent it to Staffordshire County Council Adult Safeguarding and the Care Quality Commission who may find it useful or of interest.

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.

9. Signature

24 December 2019

Senior Coroner for Staffordshire South

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