Regulation 28: REPORT TO PREVENT FUTURE DEATHS (1)

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

REGULATION 28 REPORT TO PREVENT DEATHS

THIS REPORT IS BEING SENT TO:

1 [redacted], Director New Lodge Nursing Home
2 ……
3 ……

1 CORONER

I am Robert HUNTER, Senior Coroner for the 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 23/11/2018 I commenced an investigation into the death of Shirley FROGGETT aged 84. The investigation concluded at the end of the inquest on 19 February 2021. The conclusion of the inquest was:

I a Bronchopneumonia

I b Fractured Left Femur (Operated 25/09/2018)

I c

II Osteopenia

4 CIRCUMSTANCES OF THE DEATH

Shirley Froggett died on the eighth of November 2018 at the Old Lodge Nursing Home, Sandypits Lane, Etwall, Derbyshire.

Conclusion of the Coroner as to the death:
Shirley Froggettt died of bronchopneumonia resulting from a fractured left femur which was sustained in a fall from a wheelchair in a Nursing Home. Despite a care plan being in place, requiring Mrs Froggett to be secured in her wheelchair, to prevent her from falling, the lap-strap was not applied as it was missing a buckle. The continued use of the wheelchair and the non-observance of the care plan were gross failures. As such Mrs Froggett died from an accident contributed to by neglect.

5 CORONER'S CONCERNS

The MATTERS OF CONCERNS are as follows: (brief summary of matters of concern)

On the evidence heard at inquest I was not satisfied that New Lodge Nursing Home had any robust systems in place to ensure compliance with care plans, policies and protocols.

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 26 April 2021. 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 Care Quality Commission and the son and daughter-in-law of the deceased.

and to the Local Safeguarding Board (where the deceased was 18). I have also sent it to

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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

Robert HUNTER
Senior Coroner for
Derby and Derbyshire
Dated: 01 March 2021