Regulation 28: REPORT TO PREVENT FUTURE DEATHS
Dorothy Pegg (died 25 Oct 2019)

REGULATION 28 REPORT TO PREVENT DEATHS

THIS REPORT IS BEING SENT TO:

1. [redacted], CEO Abbeyfields the Dales Limited, Grove House, 12 Riddings Road, Ilkley.
2. [redacted], Corporate Director Health and Adult Services, North Yorkshire County Council, County Hall, Northallerton.

1 CORONER

Jonathan Heath, Senior Coroner York and North Yorkshire

The Old Courthouse
3 Racecourse Lane
Northallerton
DL7 8QZ

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 the 31 October 2019 I commenced an investigation into the death of Dorothy PEGG aged 92.
The investigation concluded at the end of the inquest on 15 October 2021.
The cause of death was:
Ia Ischaemic heart disease, right bronchopneumonia
Ib Immobility
Ic General frailty; bilateral fibula and tibial fractures (managed conservatively)

The conclusion of the Inquest was a narrative conclusion:

Dorothy Pegg slipped from a shower chair whilst sitting on a sling whilst fully clothed having been transferred from the bedroom to the living room. She suffered bilateral leg fractures which have contributed to her death.

4 CIRCUMSTANCES OF THE DEATH

Dorothy Pegg was resident in the extra care facility and was hoisted when clothed from her bed into her shower chair. The hoist slip was left underneath her. She was wheeled in the shower chair to the living room and prior to being hoisted from the shower chair to her living room chair, slipped to the floor and suffered bilateral leg fractures which contributed to her death.

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 could occur unless action is taken. In the circumstances, it is my statutory duty to report to you.

The MATTERS OF CONCERNS are as follows:

1. There was no system of monitoring the compliance with instructions as to how equipment should be used.

2. There were no instructions as to the circumstances in which it is appropriate that specific prescribed equipment is used.

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.

Point 1 to be addressed by [redacted]

Point 2 to be addressed by [redacted]

7 YOUR RESPONSE

You are under a duty to respond to this report within 56 days of the date of this report, namely by 17 December 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:

[redacted]
Care Quality Commission

……

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

Jon HEATH
Senior Coroner for
North Yorkshire Western District
Dated: 22 October 2021