Regulation 28: Prevention of Future Deaths report

Dorothy Gamby (died 30 April 2025)

	THIS REPORT IS BEING SENT TO: Chief Executive Officer Office for Product Safety and Standards Cannon House 18 The Priory Birmingham B4 6BS
1	**CORONER** I am: Melanie Sarah Lee Assistant Coroner Inner North London Poplar Coroner's Court 127 Poplar High Street London E14 0AE
2	**CORONER'S LEGAL POWERS** I make this report under the Coroners and Justice Act 2009, paragraph 7, Schedule 5, and The Coroners (Investigations) Regulations 2013, regulations 28 and 29.
3	**INVESTIGATION and INQUEST** On 2 May 2025 an investigation into the death of Dorothy Gamby age 100 years. The investigation concluded at the end of the inquest on 8 May 2025. The medical cause of death was 1a. pneumonia 1b. fractured neck of femur (operated 22 April 2025). I made a determination at inquest of accident.
4	**CIRCUMSTANCES OF THE DEATH** Dorothy Gamby was 100 years old. On 22 April 2025 she suffered a fall at home when she stood on the wide claw shaped rubber ferrule that she had attached to the bottom of her foldable walking stick. This caused the stick to pull apart and the collapsible mechanism to activate when she pulled the stick up (the bottom section of the stick being held down by her foot on the ferrule). When she fell, she sustained fractures to her right hip and right wrist, and a small subarachnoid haemorrhage. On 22 April she underwent surgery for her hip fracture. Post-operatively

	she developed progressive hypoxia and Type 2 respiratory failure, secondary to known COPD. A chest xray on 25 April showed pneumonia which was treated with antibiotics. Despite this she continued to deteriorate, and given her frailty and co-morbidities, her care switched to palliative care and she died at the Whittington Hospital on 30 April 2025.
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 will occur unless action is taken. In the circumstances, it is my statutory duty to report to you. The **MATTERS OF CONCERN** are as follows. Wide and clawed ferrules for walking sticks are widely available. They are described as providing stability, support, improved safety, ease of movement, etc. I am concerned that there is no warning that they may pose a risk if stood on or trapped when used on folding/collapsible walking sticks.
6	**ACTION SHOULD BE TAKEN** In my opinion, action should be taken to prevent future deaths and I believe that 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 3 July 2025. 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 following. • Mrs Gamby's daughter, [redacted] • HHJ Alexia Durran, the Chief Coroner of England & Wales

	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 other 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.
9	**DATE** 8 May 2025 **SIGNED BY ASSISTANT CORONER**