Regulation 28: REPORT TO PREVENT FUTURE DEATHS

	REGULATION 28 REPORT TO PREVENT DEATHS **THIS REPORT IS BEING SENT TO:** **1 Frimley Health NHS Foundation Trust**
1	**CORONER** I am Robert SIMPSON, Assistant Coroner for the coroner area of Berkshire
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** On 13 December 2024 I commenced an investigation into the death of June Violet FINDLAY aged 97. The investigation concluded at the end of the inquest on the 27/11/2025. The conclusion of the inquest was: The deceased died as a result of natural causes contributed to by an accidental fall and on a background of sub-optimal care in hospital.
4	**CIRCUMSTANCES OF THE DEATH** Mrs Findlay was living at home with the assistance of family and twice daily carers. She was frail but independent and could walk with the use of aids. On the 23/10/2024 she fell at home fracturing her hip and wrist. She was taken to Frimley Park Hospital by ambulance. She underwent a intramedullary nail fixation of her hip the following day. Her wrist was placed in a cast. Mrs Findlay remained in Frimley Park Hospital until the 06/11/2024 when she was transferred to the Heathlands rehabilitation unit. By the time of this move she had lost a significant amount of weight. Mrs Findlay did not regain her mobility and her health deteriorated. Mrs Findlay moved to the Thames Hospice on the 04/12/2024 and she died on the 11/12/2024.
5	**CORONER'S CONCERNS** During the course of the investigation my inquiries 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 CONCERN** are as follows:

	(brief summary of matters of concern) During the course of Mrs Findlay's 9-10 days at Frimley Park Hospital she lost at least 5.3kg from an already low weight. She had been assessed as being at high risk of malnutrition shortly after her admission. The care planning records were inconsistent about the interventions required and the level of risk. The record keeping of the actual interventions used on a daily basis to address this risk were absent or largely incomplete and I found that the ward staff did not properly follow the dietician's advice or the care plans. I am concerned that ward staff are not: 1. Properly recognising the risk of malnutrition to patients, even after completing the MUST2 assessments; 2. Correctly utilising care planning tools to address the risks of malnutrition; 3. Properly monitoring and recording the interventions undertaken to address the risk. This places patients at risk due to unclear information and also means that the hospital cannot learn from mistakes or pick up near misses. No evidence was forthcoming from the Trust at inquest that these shortcomings at Frimley Park Hospital had been acted upon despite the court hearing that 100% of the ward staff had received MUST training and records were audited on a monthly basis. This gives rise to a further concern: 4. The auditing of records does not seem to have identified the repeated failures to record required information.
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 by February 6, 2026. 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 Mrs Findlay** 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 she 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	**Dated: 27/11/2025** [redacted] **Robert SIMPSON** **Assistant Coroner for Berkshire**