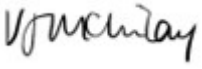
	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO: Managing Director, Prime Life Limited, 121 Knighton Church Road, Leicester LE2 3JN**
1	**CORONER** I am Vanessa McKinlay, Assistant Coroner for Birmingham and Solihull
2	**CORONER'S LEGAL POWERS** I make this report under paragraph 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 4 November 2021 I commenced an investigation into the death of Dorothy Ann SPIBY. The investigation concluded at the end of the inquest . The conclusion of the inquest was: Accidental death.
4	**CIRCUMSTANCES OF THE DEATH** Mrs Spiby suffered from dementia and fluctuating blood glucose levels caused by type 1 diabetes mellitus. She had a history of falls. On 22 October 2021 she had an unwitnessed fall in her bedroom at Tamworth Court Nursing Home, where she was a resident. The precise circumstances of the fall cannot be determined from the available evidence. Mrs Spiby sustained fractures to the eye socket and two ribs. As a result of the chest wall injuries, she developed pneumonia in hospital, from which she sadly died on 28 October 2021 at City Hospital in Winson Green. Based on information from the Deceased's treating clinicians the medical cause of death was determined to be: **1a Pneumonia** **1b Fall with right sided rib fractures** **1c** **II Dementia. Frailty. Type 1 diabetes mellitus.**

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. - 1. Tamworth Court Nursing Home staff reported to the hospital that Mrs Spiby became distressed and ran into collision with a wall when trying to leave her room, before falling to the floor. The origin of this account was unclear from the evidence. No record was made of the incident in the nursing records. 2. No incident form was completed. 3. No investigation of the accident or the circumstances giving rise to it was undertaken. 4. There was no evidence of a commitment to learning from this incident with a view to safeguarding residents in the future.
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 20th April 2022. 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] (daughter) I have also sent it to 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	**22 February 2022** Signature:  **Vanessa McKinlay** **Assistant Coroner for Birmingham and Solihull**