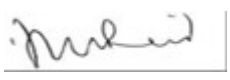
	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO:** [redacted], CEO Barchester Healthcare, 3rd Floor, The Aspect, 12 Finsbury Square, London EC2A 1AS; [redacted], Weightmans LLP, The Hallmark Building, 105 Fenchurch Street, London EC3M 5JG (legal representative for Barchester Healthcare at inquest)
1	**CORONER** I am David Donald William REID, HM Senior Coroner for Worcestershire.
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. http://www.legislation.gov.uk/ukpga/2009/25/schedule/5/paragraph/7 http://www.legislation.gov.uk/uksi/2013/1629/part/7/made
3	**INVESTIGATION and INQUEST [the details below are fictional]** On 3 August 2022 I commenced an investigation and opened an inquest into the death of Bridget GORMLEY. The investigation concluded at the end of the inquest on 8 February 2023. The conclusion of the inquest was that Mrs. Gormley died as the result of an accident.
4	**CIRCUMSTANCES OF THE DEATH** In answer to the questions "when, where and how did Mrs. Gormley come by her death?", I recorded as follows: *"On 20.7.22 Bridget Gormley, who had had an increasing number of falls since the end of March 2022, fell again at the care home in Worcester where she lived. She was taken by ambulance to the Alexandra Hospital, Redditch, where she was found to have sustained significant traumatic intracranial bleeding. She was transferred to Worcestershire Royal Hospital where, despite treatment, she continued to decline and died on 31.7.22."* The care home in question was Latimer Court Care Home, Darwin Avenue, Worcester WR5 1SP, which is owned and run by Barchester Healthcare. Latimer Court's registered home manager is Donna Tustin.
5	**<u>CORONER'S CONCERNS</u>** 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) During the course of her evidence, the inquest heard that Mrs. Gormley had suffered four falls at Latimer Court between 31 March 2022 and 4 April 2022, and a further four falls between 12 July 2022 and 17 July 2022. Latimer Court's registered home manager, [redacted], conceded in her evidence that neither

	Mrs. Gormley's Falls Risk Assessment document, nor her Falls Care plan document were updated following any of these falls, and that they should have been so updated. This meant that: (a) Staff at Latimer Court who were looking after Mrs. Gormley may not have been aware that she presented an increased risk of suffering a fall; and (b) Measures to mitigate that increased risk were not considered. Such measures could have included: (i) Asking a GP to refer Mrs. Gormley to the falls clinic; (ii) Placing a sensor mat by her bed or chair, to alert staff to when she was mobilising; (iii) Referring her to Occupational Therapy for mobility aids such as a walking stick or frame; (iv) Briefing staff at Latimer Court to intervene whenever Mrs. Gormley was seen mobilising by herself, and to offer her assistance. (2) [redacted] was unable to explain why these important documents had not been updated as they should have been by staff at Latimer Court. There is therefore concern that staff at Latimer Court did not, and may still not understand their duties and responsibilities to update residents' documentation in such circumstances.
6	**ACTION SHOULD BE TAKEN** In my opinion action should be taken to prevent future deaths and I believe you, as CEO of Barchester Healthcare, 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 **6 April 2023.** 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] (Mrs. Gormley's next of kin). 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	**9 February 2023**  **David REID** **HM Senior Coroner for Worcestershire**