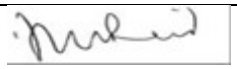
	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO:** 1) [redacted], Chief Executive, Herefordshire and Worcestershire Health and Care NHS Trust, Kings Court, 2, Charles Hastings Way, Worcester WR5 1JR ("HWHCT").
1	**CORONER** I am David Donald William REID, HM Senior Coroner 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** On 25 April 2023 I commenced an investigation and opened an inquest into the death of Anthony John Friend. The investigation concluded at the end of the inquest on 5 September 2023. The conclusion of the inquest was that Mr. Friend died as the result of an accident.
4	**CIRCUMSTANCES OF THE DEATH** In answer to the questions "when, where and how did Mr. Friend come by his death?", I recorded as follows: *"On 17.4.23 Anthony Friend, who was living with the effects of a brain tumour and required regular personal care visits at his home in Bromsgrove, sustained a significant head injury after slipping through a sling while being hoisted from a chair to his bed, and striking his head on the frame of the hoist. He was discharged from hospital back home for palliative care, and declined and died there on 20.4.23. The sling being used at the time of the fall had previously been adjudged unsuitable for his care needs, but it was not removed from his property, and no instruction had been given that its use should cease."*
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. – In the course of the inquest, I heard evidence that: 1) As long ago as 28.11.22 (nearly 5 months before the accident which led to Mr. Friend's death), [redacted], an Occupational Therapist employed by HWHCT, had concluded that the sling being used at the time of the accident on 17.4.23 (the "old toileting sling") was no longer suitable for Mr. Friend, ensured that two more suitable slings were provided instead, but did not remove the old toileting sling from Mr. Friend's property; 2) During a home visit to Mr. Friend's address on 2.2.23, [redacted] noted that the old toileting sling was still being used, made clear to Mr. Friend's

	family and carers that it was *"not safe to use"*, but again did not remove it from the property; 3) During a home visit to Mr. Friend's address on 6.3.23, [redacted], another Occupational Therapist employed by HWHCT, noted that the old toileting sling was still being used by family and carers, and that although the two more suitable slings provided by her colleague [redacted] would be difficult to fit, they were nonetheless safer to use. [redacted] told the inquest that in hindsight she *"should not have allowed [carers] to carry on using the unsafe sling"* and that she did not know why she had not taken time to show carers how to use the safer slings which had been provided; 4) During a home visit to Mr. Friend's address on 17.4.23 (just prior to the accident) in order to assess Mr. Friend for a new sling, [redacted] noted that the old toileting sling was still being used. However, she told the inquest that despite her misgivings about it, she did not remove it from the address, and still expected carers to carry on using it for the next two weeks until a new sling arrived. She described this decision as *"an oversight"* on her part; 5) [redacted] also told the inquest that: (a) she should have ensured that Mr. Friend's carers were present for the home visit and sling assessment on 17.4.23 (which they were not); and (b) she should have contacted his new carers (Divine Health Services Ltd.) after that visit, to discuss their use of the sling; 6) At no time do either [redacted] appear to have communicated their concerns about the continued use of the old toileting sling in writing to either of the agencies which were providing care for Mr. Friend at the relevant times.
6	**ACTION SHOULD BE TAKEN** In my opinion action should be taken to prevent future deaths and I believe you, as the Chief Executive of HWHCT, 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 **13 November.** 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: (a) [redacted] Mr. Friend's daughter; (b) [redacted], Director, Bluebird Care; (c) [redacted], Director, Divine Health Services Ltd. 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	**18 September 2023**

	 **David REID** **HM Senior Coroner for Worcestershire**