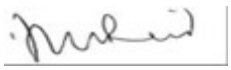
	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO:** 1) [redacted], Director, Divine Health Services Ltd., Unit 59, Basepoint Business Centre, Isidore Road, Bromsgrove, Worcestershire B60 3ET.
1	**CORONER** I am David Donald William REID, HM Senior Coroner for Worcestershire.
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) Bluebird Care provided care at home for Mr. Friend up to 16.4.23 (two days before the accident which led to Mr. Friend's death); 2) the reason Bluebird Care stopped providing care for Mr. Friend was that they had concerns about the sling which was still being used with his hoist; 3) Bluebird Care knew by 12.4.23 that Mr. Friend's care at home after 16.4.23 would be provided by Divine Health Services Ltd.; 4) At no time did Bluebird Care try to make contact with, or provide any sort of handover to Divine Health Services Ltd. about Mr. Friend's needs, or about

	any concerns they had concerning the sling. In her evidence to the inquest, [redacted], Bluebird Care's registered care manager, agreed that it was *"common sense…for there to be a good handover between care agencies"*, but that it *"was not something which we had ever done"*; 5) At no time did Divine Health Services Ltd. make any efforts to identify, contact or seek a handover about Mr. Friend from the previous care agency Bluebird Care. In his evidence to the inquest, [redacted], Director of Divine Health Services Ltd., agreed that it would be *"a matter of good practice"* to have done so.
6	**ACTION SHOULD BE TAKEN** In my opinion action should be taken to prevent future deaths and I believe you, as the Director of Divine Health Services Ltd., 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] Chief Executive, Herefordshire and Worcestershire Health and Care NHS Trust. 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**