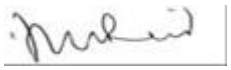
	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO:** [redacted], Chief Executive Officer, Care UK Ltd, Connaught House, 850 The Crescent, Colchester, Essex, CO4 9QB.
1	**CORONER** I am David Donald William REID, HM Senior Coroner for Worcestershire.
2	**CORONER'S LEGAL POWERS** 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 1 May 2024 I commenced an investigation and opened an inquest into the death of Edith Theresa PYE. The investigation concluded at the end of the inquest on 16 December 2024. The conclusion of the inquest was that Mrs. Pye *"died as the result of an accidental fall in a care home. Her death was contributed to by neglect"*.
4	**CIRCUMSTANCES OF THE DEATH** In answer to the questions "when, where and how did Mrs. Pye come by her death?", I recorded as follows: *"On 29.3.24 Edith Pye sustained a periprosthetic fracture to her left knee after rolling off her bed at Chandler Court Care Home, Bromsgrove, where she lived. At the time of the fall she had briefly been left unattended while receiving personal care which should have been provided by at least two carers, but at the time was only being provided by one. As a result of her injury, she underwent an above knee amputation, and went on to develop a chest infection and pulmonary emboli. Despite treatment, she continued to decline and was discharged back to the care home for end of life care, where she died on 28.4.24."*
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) At the inquest, the care home manager gave evidence that the care home recognized that Mrs. Pye was a high risk of falling or rolling from her bed, and also had a history of making unsubstantiated accusations against staff. The care home therefore required: (a) that Mrs. Pye's personal care should always be provided by no less than two carers; and

	(b) that personal care should be provided, where possible, by two female carers, and if not possible, one female carer should always be present. These requirements should have been reflected in Mrs. Pye's care plan, but the care plan was ambiguous – for example, it stated: *"Edith may require the support of 2 carers with personal hygiene needs"* and *"Edith prefers to receive care from female carers – if this is not possible with the allocated staff for the shift, assistance should be sought from another suite"*; 2) The carer who provided personal care to Mrs. Pye on the occasion when she fell from her bed on 29.3.24 knew that he should have done so with a colleague, but would regularly do so on his own. He had never himself read Mrs. Pye's care plan, and it became clear that two other members of staff who provided evidence to the inquest were also unaware of some key aspects of the care plan. Furthermore, other staff were aware that he would often provide care to Mrs. Pye on his own, but no-one had reported this to senior staff or taken any action to try to stop it happening; 3) At the inquest, I was shown a handover document which had been drafted by the home's Deputy Manager, and was told that a nurse in charge would have gone through this document with all carers at the beginning of the relevant shift. The document was meant to highlight each resident's care needs, based on their respective care plans. It did not make clear that Mrs. Pye required two carers for the provision of personal care, or that at least one of those carers should be female; 4) There was no system in place at the time for auditing these handover documents; 5) The Deputy Manager who had drafted this handover document, was also responsible for the care home's own internal investigation into Mrs. Pye's fall. That internal investigation failed to highlight the deficiencies in the handover document, and the handover document itself was not disclosed to the Coroner's Office until the final inquest hearing was underway. I am therefore concerned that insufficiently robust measures are in place at Chandler Court Care Home to ensure that the types of failure which led to Mrs. Pye's death have been recognized, can be picked up on, and are not repeated in the future.
6	**ACTION SHOULD BE TAKEN** In my opinion action should be taken to prevent future deaths and I believe you, as the Chief Executive Officer of Care UK 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 **14 February 2025.** 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], Mrs. Pye's son;

	(b) DAC Beachcroft solicitors, who represented Care UK Ltd. at the inquest hearing. 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	**20 December 2024**  **David REID** **HM Senior Coroner for Worcestershire**