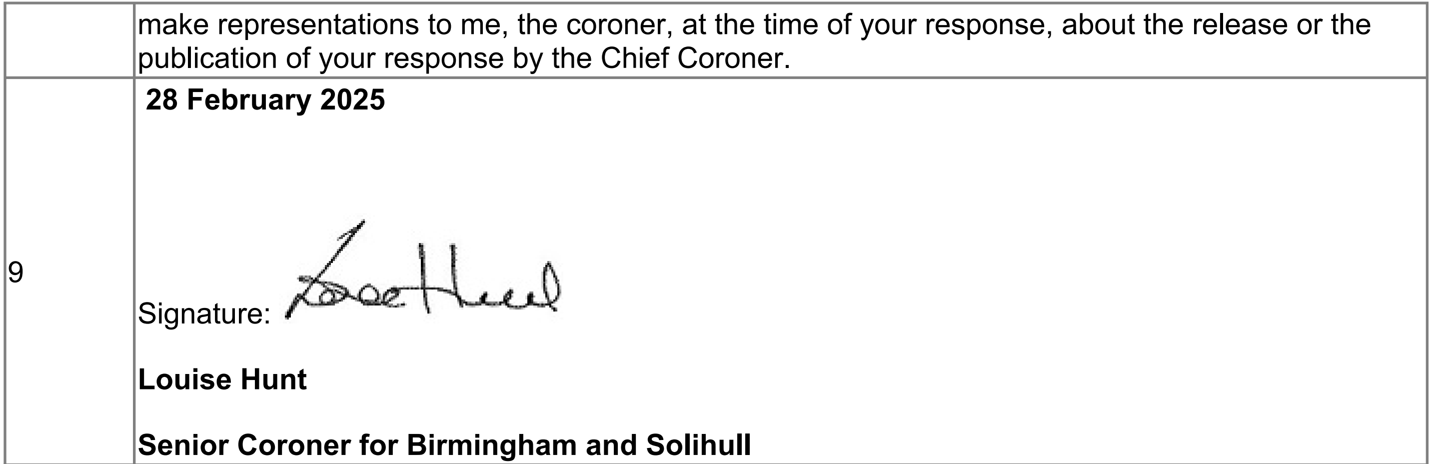
	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO:** • **Willow Grange care home**
1	**CORONER** I am Louise Hunt, Senior Coroner for Birmingham and Solihull
2	**CORONER'S LEGAL POWERS** I make this report under paragraph 7, Schedule 5, of the Coroners and Justice Act 2009 and regulations 28 and 29 of the Coroners (Investigations) Regulations 2013.
3	**INVESTIGATION and INQUEST** On 18 May 2023 I commenced an investigation into the death of June PHILLIPS. The investigation concluded at the end of the inquest. The conclusion of the inquest was; accident
4	**CIRCUMSTANCES OF THE DEATH** Mrs Phillips resided in a care home as she suffered from Alzheimer's dementia and she took clopidogrel an antiplatelet medication to reduce the risk of clots. She required help with activities of daily living but remained mobile and would walk around the care home often at a fast pace. She was assessed as at high risk of falls and had several falls due to her constant walking. At 23.05 on 07/04/23 she fell forwards in the hallway causing an injury to her forehead and back. She was assessed and not thought to have any significant injury. 111 was called who advised further monitoring. The following day she presented as normal however from 09/04/23 her condition changed, and she appeared more sleepy and her mobility declined meaning she required more assistance. On 12/04/23 she was assessed by a GP as part of the weekly ward round who noted the fall and an injury to her right eye which was now very bruised but found no abnormalities or changes so advised further monitoring. On 13/04/23 she was noted to be struggling to walk and required a wheelchair and her mobility continued to deteriorate. After concerns were raised by her husband, she was reviewed again on 17/04/23 by a GP. The GP was not advised of any deterioration in her presentation and found no abnormal neurological signs but suspected she may have suffered a concussion from the fall. The plan was for her to be seen on the next weekly ward round, and she was given eye drops for an eye infection. She was not added to the list for the weekly ward round on 19/04/23. Mrs Phillips continued to deteriorate and require assistance and on 22/04/23 she was noted to be very sleepy. By 24/04/23 she was noted to be very unwell and struggling to walk and eat and drink independently and after review by a GP she was admitted to Birmingham Heartlands Hospital where a CT scan confirmed a large right sided traumatic subdural haemorrhage which was treated conservatively until her death on 30/04/23. It is likely she suffered a head injury when she fell on 07/04/23 and that clopidogrel caused the initial injury to worsen over time but it is not possible to say whether earlier admission to hospital would have impacted on the outcome. Based on information from the Deceased's treating clinicians the medical cause of death was determined to be: **1a Traumatic Subdural Hemorrhage** **1b**

	1c **1d** **II**
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. The care home records were inaccurate and did not correctly reflect the deterioration in Mrs Phillips condition after the fall. There is a concern that this creates a risk of further deaths. 2. The risk assessment for prevention of falls was not updated when it should have been after her fall on 07/04/23 and when her condition deteriorated. There is a concern that this create a risk of further deaths as risk assessments are not up to date. 3. The post falls investigation did not adequately investigate the circumstances of the fall. There is a concern that this creates a risk of future deaths as lessons are not learnt from incidents.
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 25 April 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 Interested Persons: • Mrs Phillips' family • [redacted] • [redacted] • West Midlands Police • Solihull Metropolitan Borough Council I have also sent it to the Medical Examiner, ICS, NHS England, CQC, 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	**28 February 2025** Signature: **Louise Hunt** **Senior Coroner for Birmingham and Solihull**