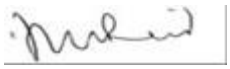
	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO:** [redacted], Green Range Limited, The Willows Care Home, 2 Tower Rd, Worcester WR3 7AF.
1	**CORONER** I am David Donald William REID, HM Senior Coroner for Worcestershire.
2	**CORONER'S LEGAL POWERS** I make this report under 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 7 November 2024 I commenced an investigation and opened an inquest into the death of Vera Kathleen FORTEY. The investigation concluded at the end of the inquest on 18 June 2025. The conclusion of the inquest was that Mrs. Fortey *"died from natural causes, to which an injury sustained in a recent accidental fall contributed"*.
4	**CIRCUMSTANCES OF THE DEATH** In answer to the questions "when, where and how did Mrs. Fortey come by her death?", I recorded as follows: *"On 29.9.24 Vera Fortey, who had recently suffered a fall in her room at the care home in Worcester where she lived, underwent a hemiarthroplasty procedure to repair a fractured hip sustained in that fall. Although making an uneventful recovery from the surgery, such that she was transferred to Wyre Forest Ward, Kidderminster Hospital for rehabilitation on 14.10.24, she became increasingly frail. Despite treatment, she continued to decline and died in Kidderminster Hospital on 5.11.24."*
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) Mrs. Fortey suffered an unwitnessed fall in her room at The Willows Care Home, Worcester shortly after midnight on 25.9.24. The carers who came and assisted her felt that she had not injured herself, and did not seek any medical attention for her. In fact, no medical attention was sought until shortly before midday on 27.9.24, when she was recorded as not being able to support her own body weight. The disclosure provided by the care home for the inquest did not contain: - any contemporaneous account of this fall written by either of the two carers who dealt with her at the time;

	- any entry made in Mrs. Fortey's Daily Notes of this fall. Furthermore, although there was a document which the then manager of the care home had written, which was said to summarize the accounts of the fall given to her by the carers concerned, this document made no reference to the date of the fall; I was forced to conclude that no contemporaneous account of the fall on 25.9.24 ever made its way on to Mrs. Fortey's file. 2) The then care home manager was informed by telephone about the fall at the time, and later on the morning of 25.9.24 reviewed Mrs. Fortey's care plans. At no time did she pick up on the fact that no account of the fall was contained on Mrs. Fortey's file. 3) Before the fall in the early hours of 25.9.24 Mrs. Fortey was able to mobilise independently. After the fall, a number of entries were made in Mrs. Fortey's Daily Notes, which referred to her: - Being unable to support herself, having bad mobility and requiring a wheelchair (1626hrs 25.9.24); - Having very bad mobility and requiring a wheelchair (1848hrs 26.9.24); - Being very confused and agitated, with very bad mobility (0713hrs 27.9.24); Despite these obvious changes in her condition, no member of staff identified that these changes might have been due to the fall on 25.9.24. Therefore in the 2½ days after the fall, several opportunities were missed to have Mrs. Fortey medically examined, and for her fractured hip to have been identified and treated sooner. A significant reason for these opportunities being missed was the fact that the original fall was not documented in Mrs. Fortey's file. 4) Although she had only been in post since 13 August 2024, the then care home manager told the inquest that a reason why she may not herself have picked up on the above failings was because at the time of these events, she was still not familiar with the care home's records system, was unable to scroll through residents' notes, and was instead just "muddling through". It therefore appears that insufficiently robust measures are in place at The Willows Care Home to ensure: (a) that staff understand the need to record significant incidents in residents' records; (b) that a regular auditing procedure is in place to help ensure that residents' records are being updated properly; and (c) that all staff at the care home (including managers) have received training so as to be as familiar with the computerized records system in use there as their role may require.
6	**ACTION SHOULD BE TAKEN** In my opinion action should be taken to prevent future deaths and I believe you, as the nominated individual responsible for the care home, 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 August 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. Fortey's daughter;; (b) [redacted], Mrs. Fortey's son. 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	**19 June 2025**  **David REID** **HM Senior Coroner for Worcestershire**