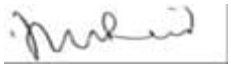
	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO:** [redacted], Chief Executive Officer, Cardinal Healthcare, Image Court, 328-334 Molesey Road, Walton-on-Thames, Surrey KT12 3LT.
1	**CORONER** I am David Donald William REID, HM Senior Coroner for Worcestershire.
2	**CORONER'S 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 12 December 2023 I commenced an investigation and opened an inquest into the death of Alfred Edward SPARROW. The investigation concluded at the end of the inquest on 6 August 2024. The conclusion of the inquest was that Mr. Sparrow *"died from natural causes."*
4	**CIRCUMSTANCES OF THE DEATH** In answer to the questions "when, where and how did Mr. Sparrow come by his death?", I recorded as follows: *"On 11.9.23 Alfred Sparrow, who lived with vascular dementia, became a resident at The Meadows Nursing Home, Catshill, Bromsgrove. During his time there, his oral intake of food and fluids would fluctuate, and he gradually became more frail. At the end of November 2023 his condition deteriorated significantly, and he declined and died there on the evening of 1.12.23."*
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) Mr. Sparrow had a longstanding diagnosis of vascular dementia, and his care plan stated that he required full assistance and support from staff at mealtimes with regard to his intake of food and fluids, and that he would not support himself if food and drink was placed in front of him. Despite the care plan, entries in Mr. Sparrow's care notes, while recording his food and fluid intake, made no mention of whether a staff member at The Meadows Nursing Home was assisting him in this regard. Having heard evidence at the inquest, I was satisfied, and found as a matter of fact, that staff at The Meadows Nursing Home did not always assist Mr. Sparrow with his food and fluid intake; 2) Furthermore, an entry in Mr. Sparrow's notes purports to show that he was given, and drank 200ml of tea at 2030hrs on 1.12.23, some two

	hours after he had died. That entry was clearly false, and gave rise to a concern that staff might have been completing care note entries which did not reflect their actions in relation to Mr. Sparrow. If that is the case, then there is a clear concern that residents' lives will continue to be put at risk by such actions; 3) The manager of The Meadows Nursing Home, [redacted], gave evidence at the inquest that, at the request of the Care Quality Commission, she carried out an investigation into the events surrounding Mr. Sparrow's death, and that she did so by looking at his care plan and care notes, and by speaking to staff who knew him. In her investigation, she failed to spot the false entry of 1.12.23 referred to above. Had she done so, her investigation would have identified at an early stage the deficiencies identified at 1) and 2) above.
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 Cardinal Healthcare, which runs The Meadows Nursing 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 **1 October 2024.** 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] and [redacted], Mr. Sparrow's daughters. 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	**6 August 2024**  **David REID** **HM Senior Coroner for Worcestershire**