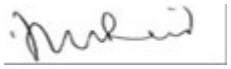
	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO:** [redacted], Chief Executive Officer, Capital Care Group, Juniper House Sitka Drive Shrewsbury Business Park Shrewsbury Shropshire SY2 6LG.
1	**CORONER** I am David Donald William REID, HM Senior Coroner for Worcestershire.
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 3 March 2021 I commenced an investigation and opened an inquest into the death of Margaret Dorothy MEDLICOTT. The investigation concluded at the end of the inquest on 1 August 2025. The conclusion of the inquest was that: *"On 23.4.20 Margaret Medlicott, who lived with dementia, sustained a severe head injury after being deliberately pushed over by another resident, who also lived with dementia, at Haresbrook Park Care Home, Tenbury Wells, where she had recently been admitted. She was taken to Hereford County Hospital where, despite treatment, she continued to decline. She died in the hospital from complications of that head injury on 3.5.20. The admissions to the care home of Mrs. Medlicott, and of the resident who pushed her, were in breach of restrictions agreed by the care home with Worcestershire County Council, and once admitted there, the assessment and management of the risks which each presented both to themselves and to others was incomplete."*
4	**CIRCUMSTANCES OF THE DEATH** The circumstances of Mrs. Medlicott's death are set out in the narrative conclusion above.
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) The resident whose actions caused Mrs. Medlicott's fatal head injury had a clear and recent history of unpredictable physical aggression towards his wife. The decision to admit that resident to the care home was made by a member of senior management without the clinical qualifications to assess whether the care home could meet his care needs, and was in clear breach of a restriction agreed by the care home with Worcestershire County Council that no person was to be admitted who presented with "physically challenging behaviour". Despite having concerns about the decision to admit him, no member of staff at the care home felt able to raise or question that decision with senior management. There is therefore a concern that staff at the care home may not understand that it is their professional duty to question such decisions, and that the care home is not providing a working environment which encourages them to do so; 2) Despite being aware of concerns about the behaviour or both Mrs. Medlicott and the other resident both before and shortly after their respective admissions to the care home, staff there failed to complete proper risk assessments and care plans addressing the risks posed by each of them to themselves and to others. Those failures were accepted, but the inquest heard no satisfactory explanation as to why they might have occurred. There is therefore concern that the staff concerned, and perhaps other staff at the care home, have not received proper training in how to carry out these important tasks.
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 **26 September 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. Medlicott's daughter and next of kin; (b) Worcestershire County Council (Interested Party); (c) Herefordshire Council (Interested Party); (d) Herefordshire and Worcestershire Integrated Care Board (Interested Party); (e) Wye Valley NHS Trust (Interested Party). 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	**1 August 2025**  **David REID** **HM Senior Coroner for Worcestershire**