Regulation 28: REPORT TO PREVENT FUTURE DEATHS

NOTE: This form is to be used **after** an inquest.

	REGULATION 28 REPORT TO PREVENT DEATHS **THIS REPORT IS BEING SENT TO:** **1 Westwood Hall Nursing Home**
1	**CORONER** I am David LEWIS, Assistant Coroner for the coroner area of Liverpool and Wirral
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 28 August 2025 I commenced an investigation into the death of Dorothy Ann MACDONALD aged 86. The investigation concluded at the end of the inquest on 10 December 2025. The conclusion of the inquest was that: During the night of 11 August 2025 the Deceased sustained a fractured neck of femur as a result of an unwitnessed fall in her bedroom at the nursing home where she had lived since being discharged from hospital in June 2025. She was taken to Arrowe Park Hospital, Arrowe Park Road, Wirral, where it was determined by clinicians that, owing to her poor underlying health and co-morbidities, she was not fit enough to undergo surgical repair of the fracture. She was placed on palliative end of life care and passed away peacefully at the hospital on 22 August 2025. Her death was due to multi organ failure brought about by the fracture.
4	**CIRCUMSTANCES OF THE DEATH** During the night of 11 August 2025 the Deceased sustained a fractured neck of femur as a result of an unwitnessed fall in her bedroom at the nursing home where she had lived since being discharged from hospital in June 2025. She was taken to Arrowe Park Hospital, Arrowe Park Road, Wirral, where it was determined by clinicians that, owing to her poor underlying health and co-morbidities, she was not fit enough to undergo surgical repair of the fracture. She was placed on palliative end of life care and passed away peacefully at the hospital on 22 August 2025. Her death was due to multi organ failure brought about by the fracture.
5	**CORONER'S CONCERNS** During the course of the investigation my inquiries revealed matters giving rise to concern. In my opinion there is a risk that future deaths could occur unless action is taken. In the circumstances it is my statutory duty to report to you. The **MATTERS OF CONCERN** are as follows: (brief summary of matters of concern) The court heard that the Deceased, aged 86, was 'tiny and very frail' on arrival at the nursing home, after being discharged from hospital following an admission lasting around 3 months. The Home Manager reported that the Deceased did not really know why she had come to the home and had a very poor short-term memory. Her previous medical history

	included Dementia and Frailty (at level 7 on the Rockwood scale), as well as Atrial Fibrillation and Chronic Kidney Disease. She was plainly rather vulnerable. The Home Manager said that her impression was that the Deceased was at a high risk of falls. The Deceased was assessed as needing to use a trolley or to have the support of staff to mobilise safely. Despite this, on multiple occasions (and even after the Deceased had fallen at the home, and had aroused concern by attempting to mobilise alone and without a trolley), staff assessed and documented her risk of falling as being at 'low' likelihood – a score of 2/5 on the likelihood scale. The Home Manager accepted that this repeated assessment was 'always wrong'. It was later increased to 3/5, classed as a medium risk. In the court's opinion this was also wrong. The likely impact of harm was assessed as 3/5 and described as 'undesirable'. This under-estimated the potential impact, as subsequent events proved. The Home Manager was unable to tell the court what rankings of 4 or 5 would represent. The Deceased died as a result of the fractured neck of femur she sustained in a fall at the Care Home. It ought to have been understood by nursing or other senior staff in a nursing home setting that such an injury would be of great seriousness in somebody presenting as the Deceased did, with a fatal outcome following hospital admission after such an injury not being uncommon. The court was told that such risk assessments might be made by any nurse, the Deputy Manager or the Home Manager, and that all had received relevant training. The court is not satisfied that the training was effective and/or was being adopted properly. In this case the assessment of the likelihood of risk was plainly wrong; and the court considers that the assessment of impact was also incorrect. As a result, the overall risk score (likelihood x impact) was understated. In this instance it probably did not make a difference to the control/mitigation measures put in place, but the court is concerned that under-estimation of an individual's falls risk could place other (current/future) residents at risk of falls which might threaten their lives. The court would like to know what steps are being taken to ensure that all relevant staff have received, understood and consistently act upon suitable and sufficient training in the assessment of falls risk. In addition, the court was shown that the nursing home's fall policy indicated that it is good practice to refer cases of falls to the 'falls team', but that in practice this was done rarely, partly because the Home Manager lacked confidence in the responsiveness or value of the service. She said that the policy did not specify how many falls should take place prior to a referral. The court would like to know how the nursing home will satisfy itself: (a) that all relevant staff have received, understood and consistently act upon suitable and sufficient education about the circumstances in which, and how, a referral to the falls team should be made; (b) that the service is sufficiently responsive and effective in responding to requests for its specialist input.
6	**ACTION SHOULD BE TAKEN** In my opinion action should be taken to prevent future deaths and I believe you (and/or your organisation) 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 February 11, 2026. 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 [redacted] I have also sent it to who may find it useful or of interest. I am also under a duty to send a copy of your response to the Chief Coroner and all interested persons who in my opinion should receive it. I may also send a copy of your response to any person who I believe may find it useful or of interest. The Chief Coroner may publish either or both in a complete or redacted or summary form. They may send a copy of this report to any person who they believe 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	**Dated: 17/12/2025** [redacted] **David LEWIS** **Assistant Coroner for** **Liverpool and Wirral**