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Miss Sarah Wood
Assistant Coroner
Nottingham City and Nottinghamshire Coroners Service
Transformation & Change
Nottingham City Council
Council House
Old Market Square
Nottingham
NG1 2DT

5 March 2026

[redacted]

Dear HM Assistant Coroner Sarah Wood,

Regulation 28 Report following the inquest into the death of Mr Ronald Colin Nelson

Thank you for bringing the Regulation 28 Report to our attention following the inquest into the death of Mr Ronald Colin Nelson who died on 26th of January 2025 at the Queens Medical Centre, Nottingham. We acknowledge the concerns you have raised and appreciate the opportunity to respond.

We would like to express our sincere condolences to Mr Nelson's family and loved ones following his death.

We have noted the matters of concerns listed below, in respect of Mulberry Court Care Home, 61 Darnhall Crescent, Bilborough, Nottingham, NG8 4QA:

i) That there remain potential issues of poor record keeping.
ii) There are concerns over the level of compliance of care plans.

We wrote to the Nominated Individual of Mulberry Court Care Home on 22 January 2026, requiring them to set out in writing, within 7 days, the action taken to date and any further planned action to meet the serious concerns identified during the inquest and the two points listed above. We received a response by return, 22 January 2026 which informed us of the following:

- The Nominated Individual had been in post since 19 July 2025;

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- The Nominated Individual had instigated on 19 January 2026, a second independent investigation to determine the short comings in connection to the care of Mr Ronald Colin Nelson. This was due to conclude by the end of February 2026 and that a copy would be shared with the Care Quality Commission (CQC) will receive a copy of this.
- The Nominated Individual submitted to CQC on 28 January 2026, a service improvement plan.
- The Nominated Individual informed CQC that they had made a formal request to the Integrated Care Board for an unannounced quality audit to be undertaken 'in the very near future'.

The CQC held a Decision-Making Meeting (DMM) on 27 January 2026 on receipt of the Prevention of Future Deaths report, to agree next steps to respond to the concerns raised.

Mulberry Court Care Home was previously inspected in January 2019, with the report published in March 2019. The service was rated good overall with the key questions of Safe, Effective, Caring and Well Led rated good. The key question of responsive was rated outstanding. In line with The CQC's current Adult Social Care (ASC) assessment priorities, Mulberry Court Care Home met the priority of a service not assessed within 6 years.

An unannounced assessment was conducted at Mulberry Court Care Home on 17 and 18 February 2026. Further off-site assessment work continued such as reviewing documents and speaking with people. This assessment looked at all key questions to determine if Mulberry Court Care Home is safe, effective, caring, responsive and well-led. Details of the assessment framework used to undertake this assessment can be found here: Assessment - Care Quality Commission.

The assessment reviewed a range of documents, systems and processes used by Mulberry Court Care Home, interviewed staff, observed clinical practice and interactions by staff and spoke with those who used the service. This has allowed CQC to determine if the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 ("The Regulations") are complied with. We have made a judgement on the standard of care including but not limited to the concerns raised within the Prevention of Future Deaths report.

The Regulations under which care planning and record keeping are reviewed are:

Regulation 9: Person-centred care - Care Quality Commission

To meet the Regulations, providers must make sure that people using a service have care or treatment that is personalised specifically for them. This regulation describes the action that providers must take to make sure that each person receives appropriate person-centred care and treatment that is based on an assessment of their needs and preferences.

Regulation 12: Safe care and treatment - Care Quality Commission

Providers must prevent people from receiving unsafe care and treatment and prevent avoidable harm or risk of harm. Providers must assess the risks to people's health and safety during any care or treatment and make sure that staff have the qualifications, competence, skills and experience to keep people safe.
Regulation 17: Good governance - Care Quality Commission

Providers must securely maintain accurate, complete and detailed records in respect of each person using the service.

We found that record keeping and care planning at Mulberry Court Care Home is in line with the regulations. The provider ensured that daily records, care plans, risk assessments and contemporaneous records in relation to care delivery were detailed, individualised updated and reviewed regularly. This meant staff knew how to care for people in the service.

Staff were knowledgeable about how to care for people in the service, because they had read and understood health records, including care plans and risk assessments, and carried out care in line with guidance and instructions in the records.

Staff had received training in tissue viability: pressure injuries training, wound healing (which included assessment, treatment and dressing). Care staff were all either trained to National Vocational Qualifications (NVQ) Level 2 or 3 or had completed a Care Certificate which included positional care, nutrition and hydration care as well as safe food handling.

We are assured that the service improvement plan to address concerns raised by you in the Prevention of Future Deaths report has been shared with staff across the service and actioned. There was a strong focus on the actions and how the service will meet them. There was a clear focus on safety. There was evidence of how lessons were learned from the death of Mr Nelson. Team meetings, reflective practice, daily huddles, handover meetings and clinical meetings were embedded.

Our assessment has concluded, however, the report is in draft and will require the standard quality assurance and factual accuracy review by the provider. Therefore, the report will not be published until after the deadline for this response. We will not advise on a provisional rating at this time, but we are assured that all matters of concern within the Prevention of Future Deaths report have been fully assessed as described above.

Consideration of Criminal Investigation

On 1 April 2015 the CQC assumed enforcement responsibility for health and safety related serious incidents concerning people using services in health and social care settings in England.

In order to determine whether to commence a criminal investigation CQC apply the “Specific Incident Guidelines”.

Under this guidance, Inspectors, supported by Operations Managers, undertake an initial assessment of specific incidents to ascertain whether there is reasonable

suspicion that people using a regulated service have sustained avoidable harm or been exposed to a significant risk of avoidable harm.

Two questions are answered as part of the initial assessment.

1. Does the information about the specific incident raise concerns about ongoing risk of harm to users of the service which CQC should inspect?

2. Does the information about the specific incident suggest the harm sustained was avoidable and may have resulted from a registered person (Provider or Registered Manager) breach of a prosecutable fundamental standard? For example, a breach of Regulation 12(1) failure to provide safe care and treatment? If so, CQC should gather further evidence about the incident as part of a formal criminal investigation once that decision has been validated by CQC National Criminal Case Assessment and Progression Panel (CCAPP).

Our National Customer Service Centre team received a statutory notification of death from Mulberry Court Care Home on 30 January 2025. This notification did not proceed for further review as the details within the notification stated the death was expected and was part of an end-of-life care pathway.

In September 2025, CQC was notified of an inquest due into Mr Nelson's death and requested information from the provider. This was to understand the actions taken in response to the incident and to assess whether there were any breaches of fundamental standards or regulatory requirements in line with our specific incident guidance.

CQC have taken steps to strengthen support for inspection teams to ensure the Specific Incident process is consistently followed in future cases in line with CQC's Specific Incident guidelines. To enhance our oversight of Specific Incidents, we have established a Specific Incident Progression Team (SIPT). This team supports inspection staff in meeting our responsibilities for incident follow-up and ensures alignment with our enforcement powers.

The incident of Mr Nelson's death was referred to SIPT on 28 November 2025. The team will consider the case to determine if it meets our regulatory threshold for enforcement action.

CQC are bound by a statutory limitation period. The statutory limitation period is set out in section 90(2) of the Health and Social Care Act 2008. It means we need to bring any prosecution both:

- within 12 months of when we have enough evidence that the case passes the test in the Code for Crown Prosecutors
- in any event within 3 years of when the offence was committed

The latest date for limitation in this matter will be 26 January 2028.

I trust that the considered response provided, alongside the actions undertaken by the Care Quality Commission, offers the necessary assurance in accordance with

our regulatory responsibilities. We will continue to monitor the provider's compliance with regulatory standards and ensure that learning from this case is embedded into practice. We remain committed to supporting improvements in patient safety and care quality across all services.

Yours sincerely,

Deputy Director of Adult Social Care
Central Region

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