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 [redacted], Chief Executive Officer, Cardinal Healthcare, Paramount House, 1 Delta Way, Egham, SURREY TW20 8RX**
1	**CORONER** I am David REID, HM Senior Coroner for the coroner area of 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.
3	**INVESTIGATION and INQUEST** On 07 May 2025 I commenced an investigation and opened an inquest into the death of George Lawrence RITCHIE aged 89. The investigation concluded at the end of the inquest on 21 January 2026. The conclusion of the inquest was that: Narrative Conclusion - Died from natural causes and the effects of a fractured femur sustained in a recent accidental fall.
4	**CIRCUMSTANCES OF THE DEATH** On 12.2.25 George Ritchie, who lived with a number of significant medical conditions, was admitted to Worcestershire Royal Hospital after suffering an unwitnessed fall at The Meadows Nursing Home, Bromsgrove, where he lived, in the early hours of that morning. He was found to have sustained a fractured hip, which was fixed surgically the following day. In the weeks following surgery he required further treatment for urinary and chest infections. He was discharged to Brindley Manor Nursing Home, Droitwich Spa on 25.3.25, where he continued steadily to decline and died on 29.4.25.
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: Although The Meadows Nursing Home's former Care Home Manager and former Clinical Lead and Deputy Manager accepted in evidence that Mr. Ritchie was a high risk of falling, the falls risk assessments and care plans in place for him from December 2024 onwards were wholly inadequate. Not only were those documents not completed properly, but there was no system of checks and oversight in place to ensure that they were being completed properly. One of those who failed to complete the falls risk assessment correctly was the Clinical Lead and Deputy Manager. There was no system in place from above her to ensure that she was doing her job correctly. From January 2025 Cardinal Healthcare's newly appointed Operations Manager, with a wealth of experience as a Care Home manager herself, was meant to address the many concerns about the Meadows Nursing Home raised in recent CQC inspections. There was no

	evidence that she had even attempted to put in place some sort of supervision or oversight at The Meadows Nursing Home to ensure that important documents like these, which played a key part in keeping residents safe, were completed properly. I am also concerned that there appears to have been no recognition by Cardinal Healthcare that night-time staffing levels at The Meadows Nursing Home at the material time were concerningly low, and required addressing. The Meadows Nursing Home may now have closed, but Cardinal Healthcare continues to operate other nursing homes in other parts of the country. I am concerned that if Cardinal Healthcare failed to put in place at The Meadows Nursing Home sufficient oversight to ensure documentation was being completed correctly, and failed to recognize and act upon low staffing levels, there will remain a risk that the lives of residents at their other nursing homes may be put at risk.
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 March 18, 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] **(Mr. Ritchie's son)** **Care Quality Commission** [redacted] **(former clinical lead and deputy manager of The Meadows Nursing Home)** [redacted] **(former manager of The Meadows Nursing Home)** 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. 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	**Dated: 21/01/2026** [redacted] **David REID**

	HM Senior Coroner for Worcestershire