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| | **REGULATION 28 REPORT TO PREVENT FUTURE DEATHS**<br><br>**THIS REPORT IS BEING SENT TO:**<br><br>Chief Executive of Worcestershire County Council |
| 1 | **CORONER**<br><br>I am Sarah Murphy, HM Assistant Coroner for Worcestershire. |
| 2 | **CORONER'S LEGAL POWERS**<br><br>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.<br><br>http://www.legislation.gov.uk/ukpga/2009/25/schedule/5/paragraph/7<br>http://www.legislation.gov.uk/uksi/2013/1629/part/7/made |
| 3 | **INVESTIGATION and INQUEST**<br><br>On 22 October 2024, I commenced an investigation and opened an inquest into the death of John Rowland Franklin. The investigation concluded at the end of the inquest on the 12 September 2025.<br><br>The conclusion of the inquest was that:<br><br>Death was due to complications of recent falls contributed to by frailty syndrome. |
| 4 | **CIRCUMSTANCES OF THE DEATH**<br><br>In answer to the questions "when, where and how did John Franklin come by his death?", I recorded as follows:<br><br>John Franklin had a medical history of malignant neoplasm of the brain and lived alone in a warden controlled flat. He was admitted to the Worcester Royal Hospital between the 1 March and 12 March 2024 for management of a left hip fracture following a fall in a restaurant. He underwent a left hip hemiarthroplasty and was discharged to the Princess of Wales Community Hospital on the 12 March, but he then developed a kidney injury and was admitted to the Alexandra Hospital.<br><br>On the 30 March he was admitted to the Malvern Community Hospital and was nursed on a pressure mattress. His engagement with physiotherapy fluctuated which led to a likely decline in his mobility and strength. He expressed that he wanted to go home and was found to have capacity. He was found to be medically fit for discharge based on overall clinical stability. On discharge, he was independently repositioning himself in the bed. A pre discharge assessment of his property was completed by occupational therapy on the 15 May which concluded that he would be able to return home safely, with assistance of carers and provision of a Molift.<br><br>Mr Franklin was discharged home on the 19 May and assessed by a Reablement Service Assessor the same day who arranged for carers to attend four times daily to support with all transfers, meals, medications, fluids and personal care. He was assessed by a reablement physiotherapist on the 20 May who noted that he had been in hospital for 7 weeks and had shown slow progress of mobility and was at high risk of further falls but was able to safely transfer with a Molift. Mr Franklin received a cognitive assessment and was noted to be able to follow conversation and to respond to |

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| | questioning appropriately. He demonstrated insight into the risks discussed and agreed that he should not attempt to stand between care calls and should wait for carers. On the 22 May, a careline was installed into the property. He then developed a urinary tract infection and commenced antibiotics on the 24 May. He was reassessed the same day by the physiotherapist who noted that he had a urinary tract infection and could not mobilise. He remained bedbound but compliant with medication.<br><br>On the evening of the 27 May, he received a care call at 20:48 hours where it was documented in the care records that a lifeline was placed around his neck. The following morning, at 9:13 hours on the 28 May, he had been found on the floor by a 'Headway' staff member, and it was noted that his pendant had not been worn. He advised that he had been on the floor since dark.<br><br>On the 28 May, he was conveyed by ambulance to the Accident and Emergency Department of the Worcester Royal Hospital and was diagnosed with a urinary tract infection and dehydration. Nursing staff completed a tissue viability assessment which included body mapping and noted normal skin to the left and right hip and a grade one sacral pressure sore. There was no evidence of a left hip infection. He was admitted to the ward and found to have lower limb fixed flexion deformity and underwent investigations for this which included blood screening, a neurology review and physiotherapy team input. During admission he developed pressure ulcers and was referred to the Tissue Viability Team on the 14 June. An electronic review noted a category 1 hip wound. He This was likely caused by the long lie on the 27/28 May at his home address. He was reviewed in person on the 17 July where the main pressure wound identified was a left greater trochanter approximately 6 inches below the previous hip operation site. The wound was reassessed by the Tissue Viability Nurse on the 24 July with no sign of infection.<br><br>Mr Franklin was transferred to the Worcester City Inpatient Unit in the 1 August where a category 3 sacral pressure sore was noted. On the 4 August a wound swab was taken from the left greater trochanter hip wound, and he was commenced on an antibiotic. The antibiotic was continued on the 12 August, and it was noted that contracted legs were causing pressure damage. On the 14 August, he was transferred the Accident and Emergency Department of Worcester Royal Hospital. He had developed a sinus tract over his left hip with surrounding redness, consistent with infection. He commenced intravenous antibiotics, but he removed his intravenous cannula on different occasions and had declined intravenous antibiotics which had resulted in treatment with oral antibiotics. Advice was sought from other medical specialities as to whether he would be eligible for tendon release procedures or botox injections to help improve his immobility, but these were not viable. The Trauma and Orthopaedic Team concluded that there were no surgical options available to treat the wound.<br><br>Mr Franklin continued to deteriorate despite multiple speciality reviews, capacity assessments and attempts to provide intravenous medication. He passed away on the 16 October 2024. Mr Franklin had become extremely frail since the initial surgery and had suffered significant deconditioning. He never truly recovered and rehabilitated. When he failed to mobilise and maintain flexibility at his hips, knees and ankles, he went on to develop contractures which reflect the tightening of the ligaments and tendons over the joint. He then developed pressure sores, despite management from the Tissue Viability Team. He developed a greater trochanter wound that was below the operation site of the left hip and did not develop an infection that involved the underlying hip implant. |
| 5 | **CORONER'S CONCERNS**<br><br>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. |

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| | The **MATTERS OF CONCERN** are as follows. –<br><br>Mr Franklin lived alone and was assessed to be at high risk of falls. When he was discharged from Malvern Hospital on the 19 May 2024, he was discharged home before a careline/lifeline pendant was provided.<br><br>At the inquest, the evidence of the manager of the Reablement team was that she did not know whether a careline had been installed at the time that Mr Franklin was found on the floor on the morning of the 28 May 2024. She informed the court that a Care Line had been requested for Mr Franklin on the 21 May 2024, and that on the 24 May 2024 during a physiotherapy assessment, Mr Franklin consented to a care line being ordered. The care notes reflected that a care line had been installed on the 22 May 2024. |
| 6 | **ACTION SHOULD BE TAKEN**<br><br>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**<br><br>You are under a duty to respond to this report within 56 days of the date of this report, namely by 24 November 2025. I, the coroner, may extend the period.<br><br>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**<br><br>I have sent a copy of my report to the Chief Coroner and to the following:<br><br>(a) The family of Mr Franklin<br><br>I am also under a duty to send the Chief Coroner a copy of your response.<br><br>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 | **16 September 2025**<br><br>**Sarah Murphy**<br>**HM Assistant Coroner for Worcestershire** |