Courts and Tribunals Judiciary

REPORT TO PREVENT FUTURE DEATHS

REGULATION 28 OF THE CORONERS (INVESTIGATIONS) REGULATIONS 2013

If during an investigation, a coroner becomes concerned about circumstances that create a risk of future deaths, Paragraph 7 of Schedule 5, Coroners and Justice Act 2009, provides coroners with the duty to make reports to a person, organisation, local authority or government department or agency where the coroner believes that action should be taken to prevent future deaths. That report is called a Prevention of Future Deaths Report (PFD report).

The Chief Coroner provides this template to support coroners in the effective and consistent exercise of their statutory duties under the Coroners and Justice Act 2009 and Regulations 28 and 29 of the Coroners (Investigations) Regulations 2013.

The purpose of the template is to provide a clear and structured framework for setting out the matters of concern identified during an investigation which, in the coroner's opinion, give rise to a risk of future deaths. It is designed to promote clarity, ensure that reports are formulated in a way that enables recipients to understand and address the concerns raised, and to support good practice across jurisdictions.

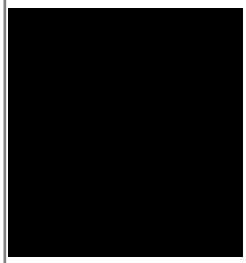
The template does not fetter judicial independence: coroners remain responsible for determining the facts, identifying the matters of concern, and drafting reports that accurately reflect the circumstances of each individual case. The template may be adapted as necessary to ensure that the report properly and precisely records the coroner's views.

In accordance with the Chief Coroner's PFD Publication Policy (2026) any applications for redactions to content or general publication of the report must be sent to the coroner. The coroner will provide the representations to the Chief Coroner for a decision.

	REPORT TO PREVENT FUTURE DEATHS **REGULATION 28 OF THE CORONERS (INVESTIGATIONS) REGULATIONS 2013** (Please do not include any living persons' names in this document, in accordance with the Chief Coroner's PFD Publication Policy (2026))
1	**CORONER** I am Emma Brown HM Area Coroner for the coroner area of Birmingham and Solihull
2	**DATE OF REPORT** **1st May 2026**

3	**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.
4	**THIS REPORT IS BEING SENT TO** **1. University Hospitals of Birmingham NHS Foundation Trust** **2.** **3.** **4.** You are under a duty to respond to this report within 56 days of the date of this report, namely by **26 June 2026**. I, the coroner, may extend the period if an appropriate application is made.
5	**YOUR RESPONSE** 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. I have a duty to send a copy of your response to the Chief Coroner. In accordance with the Chief Coroner's Publication Policy, you should send me any representations regarding the publication of your response. These representations should be made at the same time as the response is provided. I will pass any representations received to the Chief Coroner for a decision. Please note any links to webpages included in the response will not be checked for sensitive information prior to publication, as the information is already online. The names of those who do not respond to PFD reports are regularly published on the Chief Coroner's webpages Non-responses to Prevention of Future Death (PFD) reports - Courts and Tribunals Judiciary.
6	**SUMMARY OF THE CORONER'S CONCERN** 1) The number of falls occurring when the Deceased did not have supervision in accordance with his falls risk assessment. 2) The absence of evidence of a thorough investigation into all the falls with learning points and an action plan.
7	**ACTION SHOULD BE TAKEN** In my opinion unless action is taken to address the above concerns then there is a significant risk of future deaths and I believe each of you have the power to take such action.
8	**INVESTIGATION and INQUEST**

	On 4 December 2025, I commenced an investigation into the death of John McKinlay, aged 80 Years The **medical cause of death** was 1a Pneumonia 1b Chronic obstructive pulmonary disease 1c 1d II Acute on chronic subdural haematoma due to falls, Fractured neck of femur (Repaired) **How, when and where** - see below **Conclusion** The investigation concluded at the end of the inquest. The conclusion of the inquest was that death was due to a combination of natural causes alongside brain injuries and a femur fracture from a series of falls.
9	**CIRCUMSTANCES OF DEATH** *[Please explain the relevant circumstances of the individual's death, ideally this should be in no more than 500 words]* Mr McKinlay died at the Beech Hill Grange nursing home on the 19th November 2025. He had been receiving end of life care since the 7th November 2025 after it was identified at the Queen Elizabeth Hospital that he was not responding to treatment for infections and was increasingly frail. A subdural haematoma contributed to his death which was initially caused by a fall at home in August 2025 but was stable and managed conservatively. However, the effects of a fractured neck of femur also contributed: the fracture was sustained in an unwitnessed inpatient fall at Good Hope Hospital on the 11th September 2025, Mr McKinley should have been supervised as he was in an enhanced care bay on ward 28 but incorrectly no staff were present in the bay. He was transferred to Birmingham Heartlands Hospital and underwent surgical fixation of the fracture on the 13th September 2025. By the 27th September 2025 he was ready for discharge but on the 28th September 2025 he suffered a further unwitnessed fall which led to an acute bleed of the left sided subdural haematoma which contributed to his death.
10	**CORONER'S CONCERNS** During the course of the inquest I heard evidence 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: *[250-word statement addressing what circumstances of the death have led to the coroner's concern, and why the coroner thinks the person to whom the report is directed is responsible for taking action to prevent future deaths. This statement must not propose what action should be taken, as coroners cannot make recommendations].*

	The evidence from witnesses was that Mr McKinlay had a total of 4 falls whilst an inpatient at the University Hospitals of Birmingham: on the 11th September 2025 at Good Hope Hospital, 28th September 2025 at Birmingham Heartlands Hospital and on the 10th and 12th November 2025 at Queen Elizabeth Hospital. Some, potentially all, of these falls occurred when Mr McKinlay was not receiving the appropriate level of observation in accordance with his falls risk assessment and care plan. He sustained a femur fracture requiring operative fixation from the fall on the 11th September and an acute bleed of a pre-existing subdural haemorrhage on the 28th September. He did not have any investigations into the November falls as he was already receiving end of life care and there was no clinical evidence of injury. There has been a mortality review of the events at Good Hope Hospital, including the fall on the 11th September. However, evidence has not been provided of investigations into the falls at Birmingham Heartlands Hospital and Queen Elizabeth Hospital. It therefore cannot be determined that appropriate lessons have been learnt and adequate action taken creating a risk ithe situation has not improved.
11	**COPIES AND PUBLICATION OF THIS REPORT** I have a duty to send a copy of my report to every interested person who in my opinion should receive it. I also may send a copy of the report to any other person who I believe may find it useful or of interest. I can confirm I have sent the report to: *(please do not use individual's names, but instead roles/titles)* 1.The next of kin 2.Birmingham and Solihull integrated care board I also have a duty to send a copy of the report to the Chief Coroner. You may make representations to me, the coroner, about the publication of the contents of this report in line with Chief Coroner's PFD Publication Policy (2026). Any representations will be sent to the Chief Coroner alongside the report. Please refer to box 4 above for additional information relating to the publication of reports and responses.
	SIGNATURE  Emma Brown Area Coroner for Birmingham and Solihull