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 David REID, HM Senior Coroner, for the coroner area of Worcestershire.
2.	**DATE OF REPORT** 02 June 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. The Managing Director, Adept Care Homes, 1 Lutterworth Road, Burbage, Hinckley LE10 2DJ You are under a duty to respond to this report within 56 days of the date of this report, namely by July 28, 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 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 CORONER'S CONCERN** (a) staff at Bowood Court Care Home, Redditch did not understand the

	importance of updating residents' care plans and behavioural support plans; (b) management at the care home had not instituted a system of checking and ensuring those plans were updated; and (c) a subsequent internal investigation carried out by the care home failed to recognize the deficiencies in those plans, or to put in place measures to ensure that those deficiencies were not repeated.
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 you, as the Managing Director of the company which owns and runs Bowood Court Care Home, Redditch have the power to take such action.
8.	**INVESTIGATION AND INQUEST** On 05 September 2024 I commenced an investigation and opened an inquest into the death of Francis Phillip LEECH aged 80. The investigation concluded at the end of the inquest on 02 June 2026. The conclusion of the inquest was that Mr. Leech "died from natural causes, to which traumatic facial injuries inflicted by a fellow care home resident and a resulting lengthy hospital admission contributed."
9.	**CIRCUMSTANCES OF DEATH** In February 2024 Francis Leech, who lived with advanced dementia and a number of other significant medical conditions, was admitted to Moundsley Hall Nursing Home, King's Norton having spent the previous four months in hospital recovering from severe traumatic facial injuries sustained when he was struck repeatedly by a fellow resident at Bowood Court Care Home, Redditch. Over the next few months, he continued steadily to decline and died there on 26.8.24. His final decline was contributed to by the injuries which he had sustained and by the functional decline associated with the resulting lengthy hospital admission.
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: The care home resident who inflicted the facial injuries on Mr. Leech lived with advanced dementia, and over the six weeks leading up to that incident had been showing signs of unpredictably aggressive and violent behaviour. Although many of these episodes had been the subject of incident reports, neither his care plan nor his behavioural support plan had been properly updated to reflect these episodes, the risk which he presented, and measures to be taken to reduce that risk. The evidence at inquest showed that: (a) staff at the care home did not understand the importance of updating the care plan and behavioural support plan; (b) management at the care home had not instituted a system of checking and ensuring those plans were updated; and

	(c) the internal investigation carried out by the care home after the assault on Mr. Leech failed to recognize the deficiencies in those plans, or to put in place measures to ensure that those deficiencies were not repeated.
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]* • **Mr. Leech's widow and daughter;** • **The former Care Home Manager of Bowood Court Care Home;** • **The former Care Manager of Bowood Court Care Home;** • **Adult Social Care services, Worcestershire County Council;** • **The Care Quality Commission.** 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.
12.	**SIGNATURE**  **David REID** **HM Senior Coroner for** **Worcestershire**