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 Charlotte KEIGHLEY, HM Assistant Coroner, for the coroner area of West Yorkshire Western Coroner Area.
2.	**DATE OF REPORT** 03 July 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. Valorum Care Group 2. Alexander House Care Home 3. Department of Health and Social Care You are under a duty to respond to this report within 56 days of the date of this report, namely by August 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**

	i. The operation of Alexander House Care Home ii. The absence of any form of professional regulatory body (over and above the CQC) to ensure that staff tasked with caring for vulnerable elderly individuals are suitably qualified and consistently deliver safe, high-quality and effective care to provide oversight and accountability of those individuals.
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 17 September 2025 I commenced an investigation into the death of John Bryan WETTON aged 92. The investigation concluded at the end of the inquest on 11 May 2026. The conclusion of the inquest was that John Bryan Wetton died as a consequence of injuries sustained in a traumatic event, it has not been possible to determine the nature or mechanism by which John sustained his injuries or whether there was any third party involvement in the traumatic event.
9.	**CIRCUMSTANCES OF DEATH** In the early hours of the 5th August 2025, John Bryan Wetton was admitted to Huddersfield Royal Infirmary where investigations revealed that he had suffered two bleeds to his brain, a periprosthetic fracture to his right hip, bruising to his left eye and a small laceration to his nose. John's injuries were caused by a traumatic event and are consistent with John having suffered a fall in the hours prior to his admission to hospital. It has not been possible to determine the nature of the event which caused John's injuries, nor has it been possible to determine whether or not the injuries were as a consequence of third party involvement. Had John fallen, he would have been unable to get up without the assistance of more than one person and staff caring for John that evening, assert that he did not suffer a fall. In the period following his admission, John's condition continued to deteriorate and on the 21st August 2025, John was placed on the Last Days of Life pathway and passed away in Hospital at 0245 hours on the 26th August 2025.
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: i. The inaccuracy and unreliability of incident recording at Alexander

	House; ii. Incomplete documentation in respect of the care provided to residents at Alexander House. iii. Honesty and integrity of staff working at Alexander House. iv. The absence of appropriate and robust training for the Registered Manager at Alexander House in respect of safeguarding investigations to ensure thorough and complete investigation and transparency of investigation. v. The absence of any form of independent monitoring within the home to provide independent oversight of any events occurring within communal areas. vi. The absence of any form of professional regulatory body (over and above the CQC) to ensure that staff tasked with caring for vulnerable elderly individuals are suitably qualified and consistently deliver safe, high-quality and effective care to provide oversight and accountability of those individuals.
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]* • **Calderdale Adult Social Care** [redacted] • **CQC Leeds** 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** [redacted] **Charlotte KEIGHLEY**

	HM Assistant Coroner for **West Yorkshire Western Coroner Area**