Her Majesty's Coroner for the
Northern District of Greater London
(Harrow, Brent, Barnet, Haringey and Enfield)

North London Coroners Court,
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	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO:** Department of Health Richmond House 79 Whitehall London SW1A 2NS
1	**CORONER** I am Andrew Walker, senior coroner, for the coroner area of Northern District of Greater London
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 the 9th day of April 2016 I opened an investigation into the death of Arthur Thomas Adley , aged 92 years old. I opened an inquest on the 22nd day of April 2016. The inquest concluded on the 13th September 2016. The conclusion of the inquest was "Consequences of a fall", the medical case of death was 1a Cardio respiratory failure, 1 (b) blunt force trauma to the head and neck and associated complications.
4	**CIRCUMSTANCES OF THE DEATH** On the 8th April 2016 at about 7.30 Arthur Thomas Adley, who was a resident at Candle Court Nursing Home, was pushed by another resident and caused to fall striking his face and head on a table as he fell. The resident who had pushed Mr Adley was regularly assessed with regard to his suitability to remain at Candle Court Nursing Home. Steps were taken to protect other residents and the resident who had pushed Mr Adley by ensuring that there were no obstacles in that resident's way. On this occasion the member of staff looking after Mr Adley in the lounge at the nursing home was aware that the resident who was likely to push other residents was leaving the lounge but had left Mr Adley for a moment. In that moment the resident approached Mr Adley and pushed him over. This incident happened at 7.30 in the morning.

	Mr Adley was taken to hospital where he died the same day. There were 10 incidents over 3 years where the resident who pushed Mr Adley touched other residents in a way that may have resulted in a fall and on some occasions did result in the resident being pushed and falling causing injury.
5	**CORONER'S CONCERNS** 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. The **MATTERS OF CONCERN** are as follows. – That the systems for safeguarding for residents who present a risk to other residents when placed in care homes did not prevent that risk to other residents.
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 Thursday 8th December 2016 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;- I am also under a duty to send the Chief Coroner a copy of your response. 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	**13th September 2016**