Grahame Antony Short
Senior Coroner for Central Hampshire

	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO: Association of Directors of Adult Social Services**
1	**CORONER** I am Grahame Antony Short, Senior Coroner for Central Hampshire
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. http://www.legislation.gov.uk/ukpga/2009/25/schedule/5/paragraph/7 http://www.legislation.gov.uk/uksi/2013/1629/part/7/made
3	**INVESTIGATION and INQUEST** On 5 June 2017 I commenced an investigation into the death of Gordon Penistan aged, 84. The investigation concluded at the end of the inquest on 26 October 2017. The conclusion of the inquest was Accidental death. I determined that at about 14.00 on 24 May 2017 Gordon Penistan was unsettled by a loud noise at Otterbourne Grange Residential Home in Otterbourne and went from the dining room to a staircase in the home and then sustained an unwitnessed fall as a result of which he suffered an injury to his head. Mr Penistan suffered from dementia and was disorientated, having just moved to the home and he was being treated with anticoagulation therapy. He died as a result of 1a Subdural Haematoma 1b Trauma to the Head
4	**CIRCUMSTANCES OF THE DEATH** Gordon Penistan was diagnosed with posterior cortical atrophy which affected his visual perception as well as vascular dementia. He lacked mental capacity and in February 2017 he moved to a residential home capable of supporting dementia sufferers where he settled after some initial issues of aggression. The cost of the home was depleting his funds and so his family applied for local authority funding which was agreed, but Hampshire Adults' Health and Care insisted that Mr Penistan should be moved to a less expensive home that could meet his needs. From April 2017 responsibility for placement had passed to a newly formed brokerage team who lacked experience in dealing with such referrals. There was no "best interests" meeting and a lack of adequate communication with the case worker and with the family. No consideration was given to renegotiating terms with the existing care home or to the effects of a move on Mr Penistan in light of his condition. In consequence of this death Hampshire County Council instigated a Critical Incident Review as a result of which it has made improvements to the brokerage process by introducing prior senior management authorisation and further training of the brokerage team. In addition it is in the process of issuing guidance both for staff and for families about moving from self funding to local authority funding.
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. – Adults' services in other local authority areas are likely to experience similar cases and could benefit from the lessons learnt from the review in this case and the actions taken by Hampshire

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	County Council to address the shortcomings highlighted by the death. The Association would be in a position to share this information with other Adult Services.

6	**ACTION SHOULD BE TAKEN** In my opinion action should be taken to prevent future deaths and I believe you, the Association of Directors of Adult Social Services 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 27 December 2017. 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: Hampshire County Council and [redacted]. I have also sent it to the Hampshire Adult Safeguarding Board and to Otterbourne Grange Residential Home who may find it useful or of interest. 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	Dated 31 October 2017 Signature_____ Senior Coroner for Central Hampshire