REGULATION 28: REPORT TO PREVENT FUTURE DEATHS (1)

Phyllis Margaret LETCHER, deceased

	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO:** **1. Mrs Mary Anson, Cardrew House, Cardrew Way, Redruth. TR15 1SP. [Registered provider, Crossroads House Care Home, Scorrier, Redruth]**
1	**CORONER** I am Guy Davies, Her Majesty's Assistant Coroner for Cornwall & the Isles of Scilly.
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 15th March 2018 I commenced an investigation into the death of 91 year old Phyllis Margaret LETCHER. The investigation concluded at the end of the inquest on 2nd August 2018. The inquest found that Phyllis Margaret LETCHER died on 12th March 2018 at Royal Cornwall Hospital Truro from trauma following an unwitnessed fall. My conclusion as to the death is that it was an Accident. The medical cause of death has been established on the evidence as - 1a traumatic subarachnoid haemorrhage 1b fall II dementia, atrial fibrillation
4	**CIRCUMSTANCES OF THE DEATH** Mrs Letcher died from injuries sustained after falling down the staircase at Crossroads House Care Home, Scorrier, Redruth. Mrs Letcher's previous medical history included vascular dementia and atrial fibrillation with a history of falls but no injuries sustained. Mrs Letcher had limited and declining mobility – she had a stick but did not use it. Mrs Letcher was cared for by her family until February 2018, when following a social services assessment she was admitted to Crossroads House Care Home.

	Crossroads House is a specialist care home for those suffering from the various forms of dementia. Mrs Letcher was found at the foot of the staircase, staff having heard her fall on 2nd March 2018. A traumatic head injury sustained in the fall led to her death on the 12th March 2018. To the knowledge of staff, Mrs Letcher had never used the staircase prior to the fatal fall. Access to the staircase is gained through a bolted stairgate which does not require a key or a fob, and can be manually unlocked.
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. – (1) The absence of live CCTV monitoring of the staircase and other communal areas. The court heard evidence that whilst there is CCTV recording of the corridors it is not by way of a live monitored feed and does not cover the staircase. (2) The absence of a key fob access through the stairgate. The court heard evidence that whilst access from the residential quarters is controlled by key fob there is no such control of access to the staircase. (3) The absence of an alarm in the event that the stairgate is left open. The court heard evidence that the stairgate has on occasions been left open allowing unrestricted access to the staircase.
6	**ACTION SHOULD BE TAKEN** In my opinion action should be taken to prevent future deaths and I believe you and your organisation have the power to take such action, namely to review the matters of concern set out above.
7	**YOUR RESPONSE** You are under a duty to respond to this report within 56 days of the date of this report, namely by 6th October 2018. 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, namely [redacted], to share with other members of the family. I have also sent it to the Care Quality Commission 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	**6th August 2018** **Guy Davies – HM Assistant Coroner**