## REGULATION 28: REPORT TO PREVENT FUTURE DEATHS (1)

| | |
|---|---|
| | **REGULATION 28 REPORT TO PREVENT FUTURE DEATHS**<br><br>**THIS REPORT IS BEING SENT TO:**<br><br>[redacted]<br>**Head of the Roman Catholic Church of England and Wales**<br>**The Diocese of Westminster**<br>**Vaughan House**<br>**46 Francis Street**<br>**London**<br>**SW1P 1QN**<br><br>**And**<br><br>**East Coast Community Healthcare Team**<br>**Patrick Stead Hospital**<br>**Bungay Road**<br>**Halesworth**<br>**IP19 8SG** |
| 1 | **CORONER**<br><br>I am Nigel Parsley, Senior Coroner, for the coroner area of Suffolk. |
| 2 | **CORONER'S LEGAL POWERS**<br><br>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**<br><br>On 1st August 2016 I commenced an investigation into the death of Brian Alban Frost<br><br>The investigation concluded at the end of the inquest on 10th Sept 2018. The conclusion of the inquest was that the death was an accident.<br><br>The medical cause of death was confirmed as:<br><br>1(a) Head and neck injuries following a fall<br>2 Marginal zone lymphoma and ischaemic heart disease. |
| 4 | **CIRCUMSTANCES OF THE DEATH**<br><br>On the 30th June 2018 Canon Frost had an unwitnessed fall in his home at [redacted] during which he sustained severe head injuries. He was found by his next-door neighbours who called the emergency services. Canon Frost was pronounced dead at the scene at 19.52 hours by a member of the East of England Ambulance Service.<br><br>The Suffolk Constabulary conducted enquiries and concluded there was no third-party involvement in Canon Frost's death.<br><br>Canon Frost was taken to the James Paget Hospital in Gorleston, Norfolk where [redacted] conducted a post-mortem examination on the 4th July 2018 providing the cause of death as; 1(a) Head and neck injuries following a fall and 2, marginal zone lymphoma and ischaemic heart disease. |

Canon Frost was a 92yr old retired Roman Catholic priest who lived alone but had a good relationship with his neighbours. Canon Frost's neighbours attended at approximately 1100hrs the morning of 30th June 2018 and found Canon Frost in the rear garden. They went round as they heard strange noises coming from his garden and they shouted to ask if he was ok. Canon Frost replied that he wasn't, therefore they went to help him. He was found on top of a planter and couldn't get himself up. They stayed with him for approximately 30mins. Canon Frost stated he had a fall and said he had a nose bleed. He also had what is described as a graze on the top of his head and a small cut to his arm. He refused ambulance or medical assistance but was assisted by his neighbours.

The neighbours left Canon Frost's address and returned in the evening. Canon Frost's front door was unlocked as he tended to leave it during the day (normally only locking it in the evening). The neighbour entered the property as she had some fresh vegetables to give him and found him in the kitchen on his front, unresponsive with a large pool of blood underneath him.

The rear door of the property was open but there is no disturbance seen in the property, with money still remaining on his dining room table. The hob of his oven was switched on and Canon Frost was found with a slice of bread by his left-hand side.

Canon Frost was found with a large laceration to his forehead, graze to his right knee and various bruising to different parts of both arms.

Canon Frost is described by his neighbours as regularly having falls and being unsteady on his feet. Canon Frost had a bad fall in summer of 2017 and was admitted to James Paget Hospital after fracturing his hip and had had a number of subsequent falls since.

Canon frost's home was not his own but is owned by the Roman Catholic Diocese of Northampton

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 could occur unless action is taken. In the circumstances it is my statutory duty to report to you;

the **MATTERS OF CONCERN** as follows. --

1. There is a clearly identifiable history that Canon Frost had become prone to falls and was unsteady on his feet.

2. Photographic evidence produced during the inquest of Canon Frost clearly demonstrates that the floor tiles in his kitchen had become loose and were no longer fastened to the floor. One of the floor tiles is completely out of position and the others appear to be loose with large gaps between the tiles themselves. In his witness statement [redacted] commented *"the flooring where Canon Frost would have fallen was very loose and could have been a trip hazard for Canon Frost."*

3. Considering his frailty, the fact he lived alone and the medical conditions suffered by Canon Frost, on the available evidence this flooring was clearly not safe by any measure. In evidence it was heard that the flooring is sufficiently poor that it will need to be replaced prior to the re-occupation/sale of the property.

4. Evidence heard that the Bishop of each diocese is responsible under 'canon law' for accommodating retired priests of the diocese. This is generally done on a 'grace and favour' tenancy of a diocesan owned property. There is no

| | |
|---|---|
| | legal agreement for the occupation, but the general understanding is that the diocese provides the property and the retired priest is responsible for paying for all the service and maintaining the property. The retired priest receives an annual payment to cover the costs of services charges and general maintenance. It was heard that this is common practice in the 22 Roman Catholic dioceses of England and Wales.<br><br>5. It was heard in evidence that the diocese had a system of visits in place from the Clergy Welfare Officer and, if the retired priest was subject to a 'covenant of care' a Safeguarding Coordinator. Details of visits to Canon Frost's home were recorded as taking place in October 2010, December 2010, January 2011, July 2011, May 2012, January 2013, April 2014, August 2014, July 2016 and October 2017.<br><br>6. In reports compiled in relation to these visits no mention is made of any health and safety or risk assessment activity being undertaken.<br><br>7. A note from the October 2017 visit (11 months prior to Canon Frost's death) provides details of a recent fall in which Canon Frost fractured his hip, the fact he now used a walking frame and that his bedroom had been moved down stairs (following a visit from the local NHS Community Health Team). The property manager offered Canon Frost a visit from the Clergy Welfare Coordinator but this was declined.<br><br>8. Despite identifying major factors regarding Canon Frost's mobility and increasing frailty, again no mention is made of any health and safety or risk assessment activity being undertaken.<br><br>9. Giving the nature of the residents of these properties there is a degree of certainty that other 'grace and favour' residents will lose (or have already lost) the physical ability or the mental capacity to maintain their accommodation in a safe condition. On the evidence heard the system of welfare checks was not sufficiently robust and there was no independent assessment for health and safety risks. It was apparent that the current system required the resident themselves, a family member or some other third party to raise such concerns when the fabric of the building is deteriorating. The resident themselves would then need to request for the work to be undertaken.<br><br>10. Dependant on the personal circumstance of each retired member of the clergy this system appears flawed, as it relies solely on the resident retaining the mental capacity and/or the physical ability to identify that a hazard exists and then make their own request for repairs. Without doubt, the welfare system currently in place failed to identify and remedy the fact that an obvious and serious trip hazard risk was present in Canon Frost's home.<br><br>11. Given that this is the case I am concerned that other residents of 'grace and favour' homes provided by the Bishop of each dioceses, may now also be living in premises that may no longer be considered safe for their occupation.<br><br>12. During the hearing a submission was made by the lawyer representing the diocese involved that as the Local Community Health Team had also visited the property they should be included in this notice to which I agreed. A member of the Local Community Health Team visited Canon Frost on one occasion (10th November 2017) who may have seen the condition of the flooring, and if so may have been in a position to report it. However, as the owner of the home the primary responsibility for ensuring it is safe for occupation, in my opinion falls to the Roman Catholic Church. |
| 6 | **ACTION SHOULD BE TAKEN** |

| | |
|---|---|
| | In my opinion action should be taken to prevent future deaths and I believe you or your organisation have the power to take such action. |
| 7 | **YOUR RESPONSE**<br><br>You are under a duty to respond to this report within 56 days of the date of this report, namely by 28th November 2018. I, the Senior Coroner, may extend the period if I consider it reasonable to do so.<br><br>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**<br><br>I have sent a copy of my report to the Chief Coroner.<br><br>I am under a duty to send the Chief Coroner a copy of your response.<br><br>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 Senior Coroner, at the time of your response, about the release or the publication of your response by the Chief Coroner. |
| 9 | **3rd October 2018** **Nigel Parsley** |