	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO: Friendship Care and Housing Limited (Longhurst Group)**
1	**CORONER** I am Emma Brown Area Coroner for **Birmingham and Solihull**
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 22/05/2019 I commenced an investigation into the death of Mary Josephine Hoare. The investigation concluded at the end of an inquest on 12th November 2019. The conclusion of the inquest was that the deceased died due to a fall from height as a result of deliberately climbing over her balcony rail. Her intentions at the time are not known.
4	**CIRCUMSTANCES OF THE DEATH** The Deceased died at 21:11 on the 16th May 2019 at the Queen Elizabeth Hospital due to catastrophic injuries she sustained when she deliberately climbed over the balcony of her 2nd floor apartment at Phoenix House in Shirley falling to the ground below. Phoenix House provided independent living accommodation for the over 55s with the availability of extra care as required. Mrs. Hoare was receiving twice daily visits to supervise and administer her medication. Mrs. Hoare had moved into Phoenix House on the 6th May 2019 from Blenheim Hall, a residential care home to which she had been admitted on the 4th April 2019 after being discharged from the Juniper Psychiatric Centre at Moseley Hall Hospital. Mrs. Hoare had been detained for treatment and assessment under section 2 of the Mental health Act on the 27th December 2018 due to severe depression, emerging paranoid ideation and suicidal thoughts. Mrs. Hoare responded to medical management and no longer required inpatient treatment by the end of March 2019 but she had declined cognitively and was no longer capable of living independently. However, there was no formal discharge meeting before Mrs. Hoare was discharged and consequently it was not made clear to her family that the mental health team regarded an independent living setting as unsuitable. Relevant information about Mrs. Hoare's recent mental health history and stay at Blenheim Hall was not disclosed as part of her application process to Phoenix House. There were also missed opportunities to asses her overall suitability to live at Phoenix House and to determine the appropriate level of extra care she required. Consequently, although the move to Phoenix House was made with good intentions, it was not a suitable setting for Mrs. Hoare. It is not known why Mrs. Hoare climbed over the balcony. She had suffered from suicidal ideation in the past but had given no indication of a real or immediate risk of suicide and she could become confused. Based on information from the Deceased's treating clinicians the medical cause of death was determined to be: 1a) DIFFUSE AXONAL INJURY 1b) PERICARDIAL HAEMATOMA 1c) TRAUMATIC HAEMO PNEUMOTHORAX
5	**<u>CORONER'S CONCERNS</u>** 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. In April 2019, and currently, Friendship Care and Housing Limited ('FCH'), who provide care at Pheonix House, and the Solihull Care Housing Association Limited ('SCHA'), are reliant upon information from the applicant and their family when assessing the suitability of a privately funded applicant to become a resident. 2. Due to their changing circumstances and/or health, applicants and their families are not always well placed to be realistic about what the applicant's needs and risks are. Therefore there is a

	risk that full and accurate information will not be provided to FCH and SCHA. 3. In this case, the family of Mrs. Hoare assert that they were not made aware by Mental Health Teams that she was not suitable for independent living and they genuinely thought that she was. For whatever reason, full information that was known to the applicant and family about Mrs. Hoare's mental health history was not included on her application form or given in the assessment meeting held on the 5th April 2019. Specifically the assessors were not aware of Mrs. Hoare's recent treatment under section 2 of the Mental Health Act, nor that she continued to be under the care of the Community Mental Health team ('CMHT'), nor were staff informed on the 5th April 2019 that she was resident in a care home at the time of the meeting. 4. Phoenix House and other settings where FCH provide care do not routinely ask for information from applicant's General Practitioners to obtain independent current medical information. It was discussed at inquest that there are various proportionate ways this information could be sought with the consent of the applicant. 5. At assessment a full service users' assessment was not completed for Mrs. Hoare by the FCH assessor which would have been an opportunity to ask more searching questions of the applicant and her family. 6. As a consequence of the above, Mrs. Hoare became a resident of Phoenix House when she was not suitable. If information regarding her recent mental health history, ongoing management and care home residency had come to light before Mrs. Hoare became a resident it would not necessarily have prevented her being offered a unit at Phoenix House but it would have resulted in enquiries with the CMHT, her GP and potentially the care home she was in at the time of assessment. It was my conclusion that on a balance of probabilities with adequate investigations before taking up residence, it would have been determined that Mrs. Hoare could not be accommodated at that time in an independent living setting. 7. Once Mrs. Hoare was a resident, a care plan and risk assessments were not completed. 8. At inquest, evidence was given that improvements have already been made by FCH and SCHA to illicit more information from initial application forms but whilst consideration is being given to seeking information from an applicant's GP for all privately funded applicants, a decision has not yet been made. Further whilst instruction has been given to the staff members involved in this case on the importance of completing full assessments prior to and post admission, no formal training or written admission process for staff carrying out assessment across all of FCH's supported living services has been introduced. 9. Therefore it continues to be a concern that applicants may be accepted to FCH supported living settings who have not been fully assessed and who are not suitable, putting their lives at risk.
6	**ACTION SHOULD BE TAKEN** In my opinion action should be taken to prevent future deaths and I believe you 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 13 January 2020. 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: The family of Mrs. Hoare SCHA Moundesley Hall Birmingham and Solihull Mental Health NHS Foundation Trust. The report is also being sent to the following who may find it useful or of interest: The Care Quality Commission NHS Birmingham and Solihull Clinical Commissioning Group Solihull Metropolitan Borough Council, Social Services Department.

	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	15/11/2019 Signature  Emma Brown Area Coroner **Birmingham and Solihull**