Tony Brown LLM
H M Senior Coroner
North Northumberland

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REGULATION 28: REPORT TO PREVENT FUTURE DEATHS

	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO:** **Chief Executive** **Home Group** **2 Gosforth Park Way** **Gosforth Business Park** **Gosforth** **Newcastle-upon-Tyne** **NE12 8ET**
1	**CORONER** I am Tony Brown, senior coroner, for the coroner area of North Northumberland
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 14th March 2014 I commenced an investigation into the death of Stephen Peter Simpson, a fifty year old man, who died in hospital as a result of a skull fracture after a fall at home on the 14th March 2014. The investigation concluded at the end of the inquest on 10th June 2014. The conclusion of the inquest was that Stephen Peter Simpson died as a result of an accident, the medical cause of death being:- 1a Brain Haemorrhage 1b Skull Fracture
4	**CIRCUMSTANCES OF THE DEATH** Mr Simpson appears to have fallen down communal concrete stairs during late evening on 13th March 2014 and struck his head on the external door immediately at the bottom of the stairwell. Mr Simpson was showing faint signs of life when found by a neighbour the next morning and paramedics were called. Sadly he could not be resuscitated and death was pronounced at Wansbeck General Hospital at 13.50 hours.
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. – The design of the building is that there is no entrance lobby or passageway to arrest any accidental fall, with the result that any person who slips or falls while negotiating the communal stairs is liable to sustain serious injury from making impact with the solid external door. Additionally, the stairs are constructed of smooth concrete without the addition of any non-slip surface. Even if a non-slip surface was present, this would not obviate the risk of serious injury or death from impact with the external door, if a person falls from the stairs.
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 5th December 2014. 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, [redacted] 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	**DATE 09 October 2014** **TONY BROWN** **HM Senior Coroner for North Northumberland**