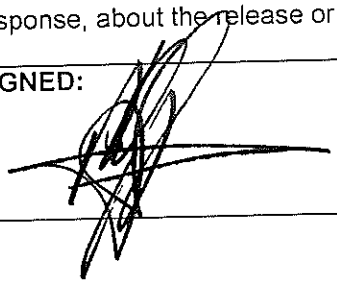
REGULATION 28: REPORT TO PREVENT FUTURE DEATHS

	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS THIS REPORT DATED 22 OCTOBER 2017 IS BEING SENT TO: **Chief Executive, Cardiff City Council.** **Family of the deceased Lesley Hanson.** **Deputy Chief Medical Officer, Welsh Government.** **Chief Coroner.**
1	CORONER I am Philip Charles SPINNEY, Area Coroner, for the coroner area of South Wales Central.
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 15 March 2016 an investigation was commenced into the death of Lesley Hanson. The investigation concluded at the end of the inquest held on 11 to 12 October 2017. The conclusion of the inquest was the answers to a series of questions raised by me and answered by the Jury: In summary the Jury concluded that the arrangements in place to reduce the likelihood that Lesley had access to the stairs were inadequate for the following reasons: • The lack of consideration given for a self-locking mechanism. • Failure to adhere to the procedures set out in Lesley's Service Delivery Plan, which stated that the bottom stairgate should be shut at all times and Lesley was only to access the stairs when supervised. • The stair-gate had been left open on a number of previous occasions by other residents. The Jury concluded that the arrangements were not adequate and the failures probably contributed to Lesley's death as she was allowed unsupervised access to the stairs.
4	CIRCUMSTANCES OF THE DEATH Lesley Hanson was a 61 year old lady who lived at The Mount, Newport Road, St Mellons. The Mount is a scheme operated by Cardiff City Council where 3 ladies lived independently in a detached house with 24 hour support and care. Lesley Hanson had severe learning disabilities from her birth and also suffered with autistic traits, epilepsy, poor stability on her feet and more recently deteriorating vision. She lacked capacity in all aspects of her life and needed constant support. She lacked the capacity to effectively communicate her needs and was extremely restricted verbally. Lesley Hanson was known to have poor stability and stairgates were fitted to reduce the likelihood of unsupervised access. On 11 March 2017 Lesley gained access to the stairs and subsequently fell sustaining injuries which sadly led to her death.
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 evidence revealed that the care and risk assessments did not appear to consider the impact of the gate being left open by other residents, the type of stair-gate and the suitability of the locking mechanism. (2) It was unclear from the evidence who had the responsibility for the environment and control measures to ensure residents safety at the property.
6	**ACTION SHOULD BE TAKEN** **(1) Consideration should be given to reviewing the process of assessing risk to service users in respect of the suitability of stairs and stair-gates in supported accommodation schemes.** **(2) Consideration should be given to reviewing the approach to risk, supervision and control in supported living schemes to ensure clear guidance on roles and responsibilities to ensure residents safety.** 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.
7	**YOUR RESPONSE** You are under a duty to respond to this report within 56 days of the date of this report, namely by **17 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 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	**SIGNED:**  **Mr Philip C Spinney** **HM Area Coroner**