REGULATION 28: REPORT TO PREVENT FUTURE DEATHS

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	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO:** **1. Care Quality Commission** **2. St John's Nursing Home, South Croydon**
1	**CORONER** I am Jonathan Landau, assistant coroner for the coroner area of South London
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 7 November 2017 an investigation was commenced into the death of Stephen Martin Verrall, aged 57 years. The investigation concluded at the end of the inquest on 30 September 2021. The conclusion of theinquest was a narrative conclusion finding that Stephen had fallen from the window of his first floor room of St John's Nursing Home, Croydon and died from his injuries two days later. There had been no risk assessment for the maintenance of the windows, the window restrictor was inadequate, and there was a failure to meet health and safety guidelines of which the home should have been aware.
4	**CIRCUMSTANCES OF THE DEATH** See 3 above.
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** are as follows. – (1) **Care Quality Commission –** I was informed that CQC did not routinely check window restrictors on inspections. I was told that it was the responsibility of providers to comply with regulatory requirements in this regard. Whilst that is uncontroversial, the death in this case, and the fact that there remained unrestricted windows in August 2021 nearly four years after this death, demonstrated that checks by the regulator are required. Responsive checks after incidents are not sufficient to prevent deaths. (2) **St John's Nursing Home –**I heard that Stephen had managed to leave the home unaccompanied on several occasions. The opportunity to do so for those without capacity and without the ability to assess risk poses a risk to their lives. I was told that the reception is not manned on the weekends and there is a risk that residents may follow visitors through the door when they leave.

6	**ACTION SHOULD BE TAKEN** In my opinion action should be taken to prevent future deaths and I believe youyour organisatios 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 26 November. 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 am under a duty to send a copy of your response to the Chief Coroner and all interested persons who in my opinion should receive it. I may also send a copy of your response to any other person who I believe may find ituseful or of interest. 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.
9	 **Jonathan Landau, HM Assistant Coroner** **1 October 2021**