Regulation 28: REPORT TO PREVENT FUTURE DEATHS

NOTE: This form is to be used **after** an inquest.

	REGULATION 28 REPORT TO PREVENT DEATHS **THIS REPORT IS BEING SENT TO:** **1 Westlands Care Home**
1	**CORONER** I am Jason PEGG, Area Coroner for the coroner area of Hampshire, Portsmouth and Southampton
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 30 May 2022 I commenced an investigation into the death of Hazel Lillian MAYHO aged 82. The investigation concluded at the end of the inquest on 26 October 2022. The conclusion of the inquest was that: The deceased died on 27th May 2022 at Winchester Hospice, Romsey Road, Winchester, Hampshire having suffered a brain injury on 19th May 2022 caused when the deceased fell in the garden of Westlands House Nursing Home, Headmoor Lane, Alton, Hampshire striking her head on a pathway. The deceased's frailty contributed to the death.
4	**CIRCUMSTANCES OF THE DEATH** Accident
5	**CORONER'S CONCERNS** During the course of the investigation my inquiries 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: (brief summary of matters of concern) The deceased was 82 years of age, was severely frail and suffered from dementia. The deceased was assessed as being at high risk of falls and had a reputation for wandering around the establishment. The deceased was not unique amongst the other residents in having such vulnerabilities. The lounge areas of the nursing home have doors leading to the garden. The garden has within it potential hazards to a vulnerable resident with a high risk of falls. The doors are kept wide open in warm weather. Whether a resident has entered the garden is only known if they are observed by a member of staff to do so. Members of staff are frequently distracted by other duties hindering their ability to fully and effectively observe vulnerable residents entering the garden. There is an absence of an effective exit control process to ensure that those with a recognised risk of entering the garden alone are prevented from doing so or an effective alert system is triggered when they do so.
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 December 21, 2022. 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 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 person who I believe may find it useful 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 by the Chief Coroner.
9	**Dated: 26/10/2022**  **Jason PEGG** **Area Coroner for** **Hampshire, Portsmouth and Southampton**