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	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO:** [redacted] Holme Farm Willow Tree Lane Marsh Chapel Grimsby DN36 5UD
1.	**CORONER** I am Paul Cooper, Assistant Coroner for the Coroner area of Lincolnshire, Myle Cross Centre, 92 Macaulay Drive, St Giles, Lincoln LN2 4EN.
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. http://www.legislation.gov.uk/ukpga/2009/25/schedule/5/paragraph/7 http://www.legislation.gov.uk/uksi/2013/1629/part/7/made
3.	**INVESTIGATION and INQUEST** 1a. Traumatic Subdural Haematoma (Operated) 1b. 1c. 2.
4.	**CIRCUMSTANCES OF THE DEATH** Name of deceased: Mrs Sandra BARNETT Following an unwitnessed fall downstairs whilst on holiday in Grimsby, which occurred at 22:30 hrs on 16/04/2021 at a holiday let hosted by Airbnb (Holme Farm, [redacted]). The deceased was admitted to Grimsby A&E before being transferred to Hull for a decompressive craniotomy and subsequently transferred to RBH on 05/05. Underwent further surgery at RPH. Post op transferred to Critical Care. Sedation was removed however patient did not wake. An EEG initially showed seizure activity. Treated with antiepileptics but her conscious level did not improve. Further imaging CT and MRI scan showed further evidence of haemorrhage in brainstem. A family conference resulted in the decision for EOL care and treatment was withdrawn. Patient continued to deteriorate and died. Death verified 21/05/2021 at 1857 hrs.
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. –

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	At the time of the fall did the staircase at the holiday home meet regulation standards as to width, depth, handrails and if not, has any remedial work been undertaken since.
6.	**ACTION SHOULD BE TAKEN** In my opinion possible 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 31/05/2022. 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 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.
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