MS N J MUNDY
H M CORONER
SOUTH YORKSHIRE (East District)

email: [redacted]

CORONER'S COURT AND OFFICE
CROWN COURT
COLLEGE ROAD
DONCASTER DN1 3HS

[redacted]

REGULATION 28 REPORT TO PREVENT FUTURE DEATHS

THIS REPORT IS BEING SENT TO: National Care Consortium Ltd

1. CORONER

I am Ms N J Mundy, Senior Coroner for South Yorkshire East

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

On the 3rd January 2023 I commenced an investigation into the death of Margaret Aitchison. The investigation concluded at the end of the inquest . The conclusion of the inquest was:

Accidental death

1a Multiple traumatic injuries

1b Fall

1c

II Ischaemic heart disease and hypothermia

4. CIRCUMSTANCES OF THE DEATH

Margaret Aitchison was a resident in the Broom Lane Care home. Her room was on the first floor of the Sitwell Unit. On the 15th December 2022 at around 10:30 p.m. there was a fire alarm activation. The fire service attended and established that it was a false alarm having being activated by one of the residents. They departed and the maintenance worker came to reset the alarm. There was conflicting evidence as to the resident checks carried out after the alarm had sounded and I found that there were either no or inadequate resident checks following the reactivation of the alarm and furthermore some if not all the fire exits were not checked following the alarm. Although it is not clear whether sleep checks were properly performed on a 2 hourly basis throughout the night, I was able to determine is that at some time after 6:00 a.m. carers discovered that Mrs Aitchison was no longer in her room and after a check of the premises which lasted up to 30 minutes, she was found at the bottom of an unheated stairwell leading to an external fire exit. She had somehow accessed what should have been a locked fire door on the landing area and having gone through, fell down the stairs sustaining traumatic injuries from which she died. She was hypothermic when found (the outside temperature was -5 degrees). I heard evidence that new systems are now in place for checking resident safety and fire door exits after an alarm has sounded and the system has been reactivated

but one of the witnesses, who was a carer at the time of the incident and has remained at the home, said that there were still no formal checks and matters hadn't changed.

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 evidence from a care worker who was at the home at the relevant time, and remains a care worker at the home, that there are still no formal systems for checking of residents after fire alarm activations, is at odds with the evidence I heard from the care manager that there had been comprehensive changes and a training programme implemented. I am concerned that the processes, protocols and expectations have not been effectively cascaded to those providing care to residents in homes. Accordingly, I invite you to consider the following and in particular whether there is a need for:

1. Further training of senior staff.

2. A requirement for senior staff to each put in place clear processes for staff to respond to fire alarm activations.

3. Training of carers, and any other relevant staff members, in terms of checking resident safety and fire door exits.

6. ACTION SHOULD BE TAKEN

In my opinion action should be taken to prevent future deaths and I believe you [redacted] 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 the **29th October 2024**. 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; Ward Hadaway, Rotherham Metropolitan Borough Council and Mrs Aitchison's family.

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.

3 September 2024

9. Signature

Ms N J Mundy, Senior Coroner for South Yorkshire East