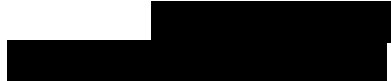




Coastal Homecare - Hove Branch
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BN3 3RU



12th May 2026

Karen Taylor

Assistant Coroner for West Sussex, Brighton & Hove
Woodvale, Lewes Road, Brighton
East Sussex, BN2 3QB

Dear Coroner,

RE: Regulation 28 Report to Prevent Future Deaths - John Malcolm Fisher, who died at the Royal Sussex County Hospital on 4th May 2025.

Thank you for your report to Prevent Future Deaths dated 19th March 2026 concerning the death of John Malcolm Fisher on 4th May 2025. In advance of responding to the concerns raised I would like to express my condolences to Mr Fisher's family and loved ones. Coastal Homecare would like to reassure the family and yourself that the concerns relating to Mr Fisher's care have been listened to and reflected upon.

Your Report raised concerns regarding the safe transfer, reconciliation, and verification of medication information when care is handed over between hospital services, Urgent Community Response teams, pharmacies, GPs, and domiciliary care providers operating within the community.

You asked that consideration be given to strengthening guidance, communication pathways, and verification processes to support community-based care providers responsible for delivering medication administration within non-clinical home environments. In particular, concerns were identified regarding the reliance by care organisations on handwritten medication administration records when onboarding patients, the absence of a fully integrated health and social care system, and the lack of clear information relating to current prescribed medication, dosage, timing, formulation, and method of dispensing available to care organisations. Concerns were also raised regarding the absence of robust cross-checking arrangements during transfers of care between agencies and limited liaison with community pharmacy services where discrepancies or uncertainty existed.

You further highlighted the importance of ensuring that community care providers have sufficient safeguards, escalation procedures, and access to accurate medication information to reduce the risk of discontinued medication being administered or essential medication being inadvertently omitted during transitions of care.

Please see the enclosed response from Coastal Homecare, setting out the actions taken following the coroner's concerns, including the review of policies, strengthening of medication verification processes, implementation of additional safeguards, and wider organisational learning identified through this incident.

Response from Coastal Homecare

We extend our sincere condolences to Mr Fisher's family and loved ones at this difficult time. Coastal Homecare has been providing domiciliary care services across Brighton & Hove for more than 10-years and has supported in excess of 4,000 people within the local community during that time. Everyone working within the care profession does so with the intention of providing safe, compassionate, and person-centred support. The safety and wellbeing of the people we care for remains our highest priority, and we are committed to working openly and collaboratively with our health and social care partners to ensure that learning is identified, shared, and acted upon.

Our involvement in Mr Fisher's care was for 6 days between 16 April 2025 and 21 April 2025. During this period, we provided three care visits per day, delivered by two care assistants, to support with; personal care, medication administration, and general welfare monitoring.

As a domiciliary care provider, we support people who choose to remain living independently within their own homes. Unlike a clinical setting, home care is delivered within an individual's personal home environment, where information, medicines, and support arrangements are often managed across multiple services and systems. This can create additional challenges and risks in relation to communication, oversight, and the timely verification of clinical information. In carrying out our role, we therefore rely upon the accuracy and completeness of information shared with us at the point of referral, assessment, and transfer of care.

In this case, we acknowledge that the medication information available to us at the commencement of the package of care did not fully reflect Mr Fisher's current needs, and that we accepted a medication summary and paper Medication Administration Record (MAR), issued by hospital services without sufficient further verification.

We had previously supported Mr Fisher as part of our longstanding role within the local community working alongside NHS Sussex Community Foundation Trust (SCFT), Urgent Community Response (UCR). Upon resumption of care, staff relied upon the information available at the time, including the documentation provided and discussions held during handover. Considering the coroner's findings, we are reviewing our safeguards and verification processes to determine where further improvements may be appropriate.

Our focus since receiving the coroner's report has been on careful reflection, organisational learning, and strengthening our practice to reduce the risk of similar circumstances arising during handover in the future. We have undertaken a review of our policies, procedures, and operational processes and have introduced several additional safeguards.

Implementation of Safeguards

The following changes have now been implemented:

- At the commencement of all new packages of care, staff now take photographic records of all medications present within the home at the point of assessment and onboarding. This additional safeguard goes beyond previous internal practice and is intended to support more accurate reconciliation of medication information and escalation of discrepancies.
- We have strengthened our medication auditing and handover processes. Staff are now required to cross-check medicines currently present in the home against available prescribing records, previous administration records, and referral documentation to identify any inconsistencies at the earliest opportunity.
- At the time Mr Fisher was receiving support from our service, GP Connect access was not available to our digital platform. Since October 2025, we have fully integrated GP Connect to our digital platform, and into current practice as an additional safeguard to support safer medication management and continuity of care. Subject to appropriate consent arrangements and patient opt-out rights, authorised staff are now able to review GP medication summaries to verify prescribed medicines and identify recent medication changes during referral, assessment, and handover processes. This has strengthened our ability to cross-check medication information and identify discrepancies at an early stage. We recognise, however, that some medication changes initiated within hospital settings, Urgent Community Response services, or other secondary care pathways may not always be immediately reflected within GP Connect records. Our revised procedures therefore also require liaison with relevant healthcare professionals, including pharmacists, and specialist teams, where appropriate, to support safe and accurate medication management.
- We now formally record the dispensing pharmacy responsible for each person's medication and have strengthened escalation procedures requiring liaison, where appropriate, with pharmacists, GPs, hospital-based community services, specialist nursing teams, and other relevant healthcare professionals to support safe continuity of care and accurate medication management. While we work collaboratively with these services, we recognise that health and social care systems are not fully integrated and information is often held across separate records and organisations. Our revised procedures are therefore intended to improve communication, verification, and escalation where discrepancies or uncertainties are identified.
- All staff are now required to complete additional Epilepsy Awareness training as part of our ongoing commitment to strengthening knowledge, understanding, and safe practice across the service. Additionally, representatives of the organisation have attended the Local Authority's Medication Adults: Epilepsy Awareness, Seizure Management and Buccal Midazolam training to further enhance our medication management procedures through continued learning.

We also recognise the importance of openness, reflection, and continuous improvement following this tragic event. Mr Fisher had a longstanding diagnosis of epilepsy, a condition which

carries an inherent risk of sudden and potentially fatal seizures. We understand from the information available that there had been periods where prescribed epilepsy medication management had varied. We do not seek to comment on medical causation beyond the findings made by the coroner. However, we remain fully committed to learning from this case, strengthening staff oversight and training, and continuing to work collaboratively with health and social care professionals to promote the safest possible care for the people we support.

Care Quality Commission Inspection and Feedback

Since this incident, Coastal Homecare has also undergone an in-person inspection by the Care Quality Commission (CQC). Initial post-inspection feedback provided to the service identified several areas of positive practice and acknowledged the organisation's commitment to learning, safeguarding, and continuous improvement.

The CQC noted that people were safe in the care of Coastal Homecare and found that safeguarding concerns, incidents, and risks were appropriately documented, escalated, and monitored for patterns or trends, no areas of concern were identified in the initial feedback. The Inspector also recognised that learning opportunities were actively identified and used to reduce the risk of recurrence. Feedback highlighted positive partnership working with external agencies and healthcare professionals to help keep people safe, alongside robust recruitment, staff training, and governance arrangements.

The inspection further recognised that medicines were being managed safely and that strengthened quality assurance processes provided effective oversight by management and office staff. The Inspector found that care plans were regularly reviewed and updated, referrals to external professionals were made appropriately, and staff demonstrated a good understanding of areas including mental capacity, safeguarding responsibilities, and person-centred care.

Importantly, the CQC identified a strong organisational culture centred on openness, reflection, learning, and staff support. Inspectors noted that staff felt confident raising concerns and described management as approachable and responsive. Feedback from people using the service and their relatives described staff as kind, caring, and respectful, with positive relationships developed between care staff and the people they supported.

We are currently awaiting publication of the CQC's full inspection report and will continue to review and reflect upon any further findings or recommendations once available. We remain committed to engaging openly with regulators and to ensuring that any additional learning identified is incorporated into our ongoing service improvement work.

We hope that the actions taken, and the learning identified through this process, will contribute positively towards reducing the risk of similar circumstances occurring in the future.

Yours Sincerely,



Registered Manager

Coastal Homecare - Hove Branch