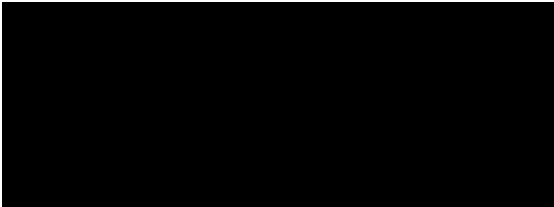


**REPORT TO PREVENT FUTURE DEATHS
REGULATION 28 OF THE CORONERS (INVESTIGATIONS) REGULATIONS
2013**

Please do not include any living persons' names in this document, in accordance with the Chief Coroner's [PFD Publication Policy \(2026\)](#).

1.	CORONER I am Rebecca SUTTON, Assistant Coroner, for the coroner area of County Durham and Darlington.
2.	DATE OF REPORT 21 May 2026
3.	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.
4.	THIS REPORT IS BEING SENT TO 1. Peterlee Care Home You are under a duty to respond to this report within 56 days of the date of this report, namely by July 16, 2026. I, the coroner, may extend the period if an appropriate application is made.
5.	YOUR RESPONSE 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. I have a duty to send a copy of your response to the Chief Coroner. In accordance with the Chief Coroner's Publication Policy, you should send me any representations regarding publication of your response. These representations should be made at the same time as the response is provided. I will pass any representations received to the Chief Coroner for a decision. Please note any links to webpages included in the response will not be checked for sensitive information prior to publication, as the information is already online. The names of those who do not respond to PFD reports are regularly published on the Chief Coroner's webpages Non-responses to Prevention of Future Death (PFD) reports - Courts and Tribunals Judiciary .
6.	SUMMARY OF CORONER'S CONCERN I am concerned that Mrs Barnett was left unsupervised in the lounge area. I

	am concerned that there is risk that future deaths could occur if residents who are suffering from reduced mobility and cognitive impairment and who are at high risk of falls are left unsupervised in the lounge area of the care home.
7.	ACTION SHOULD BE TAKEN In my opinion unless action is taken to address the above concerns then there is a significant risk of future deaths and I believe each of you have the power to take such action.
8.	INVESTIGATION AND INQUEST On 19 March 2026 I an investigation was commenced into the death of Patricia Mary BARNETT aged 84. The investigation concluded at the end of the inquest on 21 May 2026. The conclusion of the inquest was that: On 13 March 2026, at the Peterlee Care Home, County Durham, the deceased died due to a head injury sustained in an unwitnessed fall at the Peterlee Care Home on 26 February 2026.
9.	CIRCUMSTANCES OF DEATH Mrs Barnett suffered from Alzheimer's Dementia and was unable to mobilise independently. During the late evening of 26 February 2026 Mrs Barnett was in the lounge area of the care home. She had been given medication to "manage her behaviour" and was reported to be sleepy. She was known to be at high risk of falls due to attempting to mobilise without assistance. There had been members of staff present in the lounge are in order to monitor the residents (including Mrs Barnett), but the staff had left the area to assist another resident to go back to their room. While Mrs Barnett was left unsupervised in the lounge area, she had an unwitnessed fall. As a result of that fall she suffered a serious injury to her head, which resulted in her death on 13 March 2026.
10.	CORONER'S CONCERNS During the course of the inquest I heard evidence 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: I am concerned that Mrs Barnett was left unsupervised in the lounge area. I am concerned that there is risk that future deaths could occur if residents who are suffering from reduced mobility and cognitive impairment and who are at high risk of falls are left unsupervised in the lounge area of the care home.
11.	COPIES AND PUBLICATION OF THIS REPORT I have a duty to send a copy of my report to every Interested Person who in my opinion should receive it. I also may send a copy of the report to any other person who I believe may find it useful or of interest.

	I can confirm I have sent the report to: <i>[please do not use individual's names, but instead roles/titles]</i> •  • CQC I also have a duty to send a copy of the report to the Chief Coroner. You may make representations to me, the coroner, about the publication of the contents of this report in line with Chief Coroner's PFD Publication Policy (2026). Any representations will be sent to the Chief Coroner alongside the report. Please refer to box 4 above for additional information relating to the publication of reports and responses.
12.	SIGNATURE  Rebecca SUTTON Assistant Coroner for County Durham and Darlington