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Ms Melanie Lee

HM Area Coroner for West London

Coroner's Court

25 Bagleys Lane

Fulham, London

SW6 2QA

[redacted]

3 September 2026

Dear Ms Lee,

Response to the Regulation 28 report in the Joan Marie Murphy Inquest

We write in response to your Prevention of Future Deaths report (PFD) issued on 10 July 2026 following Joan Murphy's Inquest.

Your letter was received by Deer Park View care home on the 13 July 2026 who then shared it with our Inquests team.

By way of background, on 18 December 2025, Care UK took over the care provision within all care homes formerly run by Aria Care which includes Deer Park View. Care UK has a dedicated team that supports our care homes with Coroners' Inquests. This team communicates directly with Coroner's officers and ensures that Coroner's directions are complied with in due time.

I am a Solicitor having qualified in 2022.I joined Care UK in 2019 and have oversight of Coroners' Inquests that Care UK is involved with.

At Care UK we take any Prevention of Future Deaths report very seriously and we appreciate the opportunity to investigate the concerns outlined in your report.

Your concerns were considered by Care UK`s Safety Incident Learning Forum (SILF) where the feedback provided by [redacted], the Home Manager of Deer Park View, and [redacted] (the Regional Director who manages [redacted]) were discussed, and relevant Care UK policies and practices were reviewed. This forum includes Care UK's Director of Care, Quality and Regulatory Governance ([redacted]); Head of Nursing and Care, ([redacted]; Head of Dementia and Lifestyles [redacted]); Head of Health & Safety ([redacted]); and the Head of Regulatory Governance [redacted], among others.

This is the feedback they provided:

A. Lack of response to the personal alarm query

You raised a concern regarding the lack of response to your query as to why Joan Murphy did not have a pendant/wearable/personal alarm at the time of the incident.

[redacted] acknowledges that this query was not addressed as it should have been and she has extended her apologies for this oversight. She explained that while the Deputy Manager aimed to respond to various queries raised regarding the incident by various stakeholders, she appreciates that this should have been addressed, and she explained that this was an oversight and no disrespect was intended to the Court.

As previously mentioned, Care UK took over the care provision of Deer Park View from 18 December 2025. At the time that HM Coroner opened this investigation (30 January 2026), only 43 days had passed in the transition onto Care UK policies and practices. Deer Park View missed sharing the Coroner's queries with our Inquests team, who would have liaised with the relevant parties and responded to those queries in a timely manner as per our protocol.

To prevent this happening in the future, a communication has been sent to all the newly acquired care homes, to ensure that our care homes are fully familiar with our policies and procedures when dealing with Coroner's Inquests.

B. Falls on bathroom floor

You also raised a concern that "*Joan was known to be at high risk of falls. On 15 January 2026 she suffered a fall to the floor in her en-suite bathroom and was unable to get up. The emergency alarm cord in the bathroom hangs from the ceiling and it was the R23 evidence of the Deputy Manager that Joan would not have been able to reach it from the bathroom floor. Joan managed to shout repeatedly and attract attention but strained her voice and was left hoarse doing so. I presume that the bedroom door as a minimum was a fire door. Another resident may not be able to shout or otherwise summons attention, and this could result, for example, in a long lie. Joan did not have a pendant/wearable/personable alarm*."

Joan Murphy was admitted to Deer Park View for a respite stay; which is usually no more than four weeks. The electronic care system (PCS) has a function that creates a respite care plan titled "Quick care plan" specifically designed for short stay admissions. However, there is a limited range of templated fields to complete compared to the fuller version for a permanent resident. Promptings to consider sensor equipment that would have been considered for a permanent resident and discussed with Joan Murphy were not included.

Deer Park View did not have pendant alarms at the time of the incident, and to the best of Erika Slavik's knowledge, the care home had not previously used or held such equipment. However, alternative equipment such as sensors (for chair, floor or beds) and call bells were available.

In relation to the bathroom cord for the room where Joan resided, it was confirmed that this extended to the floor from the ceiling which is in line with expectations. We appreciate the concern that a resident who falls in a bathroom may be unable to reach the cord to summon help and the suggestion that a wearable/pendant alarm might

minimise that risk. However, wearable alarms are not suitable for every resident at risk of falls nor would everyone be comfortable wearing one at all times. For this reason, falls risk mitigation is part of Care UK's person-centred care which requires a balance between mitigation and promoting enablement and independence wherever possible as part of supporting residents to live fulfilling lives. This may include sensor equipment, assistance call systems, regular welfare checks and other appropriate measures. Therefore, the risk of a long lie in these particular circumstances is mitigated not solely through the use of pendant alarms.

Finally, the care provision in Deer Park View is crafted to create regular opportunities for residents to be contacted by the care team throughout the day and standard welfare checks are carried out throughout the night. These include, amongst others, medication rounds, tea rounds, activities and welfare checks. In Joan Murphy's case, her care records reflect regular staff engagement on the day of the incident.

Actions taken to address the concerns raised:

1. Deer Park View has now implemented the Care UK Respite Pathway *How* to *Guide* – Completing a *Respite Care Plan* ([redacted]), to ensure that a Multifactorial Falls Risk Assessment (MFRA) is completed when people come to the Home for respite care. This ensures that relevant risks are identified and appropriate mitigation measures are considered. These measures may include a range of assistance call systems and equipment, including pendant devices, as set out in our Call Bell Use and Management Oversight ([redacted]). Such systems are intended to alert the care team when a resident may require assistance.

2. Deer Park View has ordered pendant alarms to ensure that all assistance call systems and equipment are available for residents who require them.

[redacted]

Care UK