Portsmouth CITY COUNCIL

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Date: 21 August 2026

Dear Madam,

Prevention of Future Deaths Report (Regulation 28) following the inquest into the death of Sandra Moon

I am writing to you following receipt of the Prevention of Future Deaths Report, shared by your Officer, [redacted] on 18th July 2026. This followed the inquest of Sandra Moon on 24th and 25th June 2026.

Matter of Concern

The summary of your concern is that a person of impaired cognition and physical ability was able to access a stairwell and fall down 9 steps.

Portsmouth City Council Adult Social Care has carefully considered the concern identified within your report and welcomes the opportunity to set out the actions taken in response.

We also fully acknowledge the seriousness of this concern and the tragic circumstances surrounding Sandra Moon's death. Our thoughts remain with Sandra's family, fellow residents at Russets Care Home and the staff who supported her.

Following the incident, the Council has acted to try to understand the circumstances, identify learning and determine what improvements were required. Our investigations, and indeed the inquest, have unfortunately not been unable to conclusively establish how Sandra Moon gained access to the stairwell.

However, I can confirm that several actions were taken immediately and subsequently to reduce the risk of a similar incident occurring in the future at Russets. These have included implementing and refining a range of environmental controls and safety improvements in the building and improving individual risk management measures to reduce the likelihood of a recurrence.

Environmental Controls / Safety Improvements

A review of the stairwell access was undertaken immediately following the incident. At the time the responsibility for the building was managed via a Private Finance Initiative (PFI) so the post incident review was conducted in conjunction with the contractor.

As a result, a **fob-controlled access system** was installed on the stairwell and exit doors to restrict access to authorised individuals only and provide a significantly enhanced physical control for residents who may be vulnerable due to cognitive or physical impairment.

Risk Assessment and Care Planning

The learning identified from the incident reinforced the importance of undertaking dynamic and situation-specific risk assessments, particularly for individuals who are largely independent, but who present with complex health needs.

The introduction of the controlled access systems led to the development of clearer, risk-based criteria for the allocation of key fobs. Decisions regarding key fob provision are now informed by individual assessments of:

- Mobility
- Cognitive ability
- Health conditions
- Mental capacity related to environmental risks
- Previous behaviour

These assessments are recorded within each individual's electronic care plan.

Subsequently, in April 2026 Adult Social Care commissioned an updated Health and Safety inspection of the Russets building. This site visit, undertaken by members of the Health and Safety team at Portsmouth City Council, was to seek assurance on the measures implemented and undertaken and to review the current arrangements.

Following the visit, the Health and Safety Team shared the following recommendations:

Recommendations

The measures detailed appear appropriate, provided they are consistently adhered to and appropriately documented.

It was noted during the visit that service users had not been issued with key fobs.

It was strongly recommended that a set of middle access doors were fitted with warning alarms to activate in the event of unauthorised operation, such as the doors being forced open. This recommendation was made particularly considering an incident where a short-term young service user had successfully forced open a door despite the magnetic locking system being in place.

As the end doors were already fitted with alarm systems, a fact verified by the contractor, it was considered prudent to install similar alarms on the middle doors as an additional control measure.

Subsequent Actions

Following this subsequent Health & Safety inspection and the recommendations of that inspection, Adult Social Care met with the contractor to determine the feasibility of implementing the third recommendation and a **door alarm system** was installed on the stairwell door after a subcontractor working on behalf of the contractor, confirmed that the installation of warning alarms on the middle doors was both feasible and capable of being implemented.

This now provides an additional layer of protection by alerting staff if the stairwell door is opened, thereby strengthening the existing access control arrangements.

These new controls addressed a previously unforeseen risk, as Sandra Moon had no prior history of attempting to access stairwells and always mobilised independently using the lift.

This risk has not been identified previously in any of the inspections undertaken by the Care Quality Commission, Council Health and Safety Team or Fire Safety colleagues including Hampshire and Isle of Wight Fire and Resue Service.

Overall, appropriate environmental controls have now been introduced, risk assessment processes have been strengthened, and governance oversight has been embedded within the service.

In addition, a further fire safety inspection was also commissioned to provide assurance regarding the effectiveness of wider building safety arrangements.

Learning and Risk Management

Recognising the potential relevance of this learning at Russets across other services run by Portsmouth City Council, risk assessments of stairwells have also been commissioned within all other Portsmouth City Council registered and unregistered care settings that operate across more than one floor.

The further visits undertaken include at all of our Council Day Services, Residential and Nursing Services. Following each visit managers have been issued with an advice note from the Health & Safety Team and no further remedial action was required at any of the sites to address a similar risk.

Safeguarding and Governance Improvements

The Council also reviewed its organisational response to the incident and identified opportunities to strengthen safeguarding governance arrangements. **A Safeguarding Improvement Board**, chaired by the Deputy Director of Adult Social Care, has been established to oversee safeguarding improvements and ensure that learning from serious incidents is translated into sustainable service improvement actions. The Board is supported by a directorate-wide improvement plan that is subject to regular monitoring and review. In parallel, Adult Social Care has strengthened its quality assurance and governance arrangements and is reviewing its serious incident framework to improve the escalation, monitoring and organisational learning arising from significant events.

Findings from independent inspections and service reviews are also used to inform continual improvement across Adult Social Care services.

Wider Learning

This very tragic incident has identified potential learning for all care settings where people who use wheelchairs may be at risk near stairwells, beyond Portsmouth City Council settings. It is therefore our intention to share the learning and publicise the risk, through our various local, regional and national networks including through the Portsmouth Safeguarding Adult Board and the regional Association of Directors of Adult Social Services.

Conclusion

Portsmouth City Council extends its sincere condolences to Sandra Moon's family. Whilst it has not been possible to establish definitively how Sandra Moon gained access to the stairwell on this occasion, the Council has taken significant action to mitigate the risk of recurrence. These actions include the installation of a **fob-controlled stairwell access system**, the subsequent installation of a **stairwell door alarm**, wider environmental risk reviews, service-wide learning arising from the Critical Incident Review, and the oversight of the **Safeguarding Improvement Board** to strengthen organisational oversight and learning. We believe these measures substantially reduce the likelihood of a similar incident occurring in the future and address your concerns at set out in the Prevention of Future Deaths Report.

Just to note there is an error with the date in section 9 of the Coroner's Report, it should read 26th July **2025**.

Yours sincerely

[redacted]

[redacted]
Deputy Director of Adult Social Care