

REGULATION 28: REPORT TO PREVENT FUTURE DEATHS (1)

*NOTE: This form is to be used **after** an inquest.*

	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS THIS REPORT IS BEING SENT TO: The Chief Executive: Sanctuary Housing Association
1	CORONER I am Nicholas Graham, Area Coroner for the Coroner area of Oxfordshire.
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.
3	INVESTIGATION and INQUEST On the 18 December 2025 I commenced an investigation into the death of Caroline Oliver, aged 88 years. The investigation concluded following a hearing on the 13 April 2026. The conclusion of the Inquest was a short-form conclusion of accidental death, and that Mrs Oliver died following complications arising after a fractured neck of femur sustained in a fall at her home.
4	CIRCUMSTANCES OF THE DEATH Mrs Oliver lived independently in a property owned by Sanctuary Housing. In the weeks prior to her fall, contractors acting on behalf of Sanctuary Housing carried out works on the property. In order to facilitate these works, items stored in the loft were removed and placed in the living room of the property. Evidence heard at the inquest established that: • The boxes removed from the loft remained in Mrs Oliver's living room for nearly four weeks. • During this period, Mrs Oliver and her family made requests for the boxes to be removed, which were not acted upon. • The boxes were stacked in an orderly manner but significantly reduced the available space, leaving a narrow walkway within the living area.

	This arrangement materially restricted Mrs Oliver's ability to move safely around her home. Mrs Oliver fell in the living room on 8 December 2025 and was later found injured in the confined space between her armchair and the stacked boxes. It is not possible to determine whether the presence of the boxes caused Mrs Oliver's fall, and no such finding is made. However, the evidence demonstrated that their prolonged presence created a mobility hazard within the property.
5	<u>CORONER'S CONCERNS</u> During the course of the inquest, the following matters of concern arose. (a) Hazard created by prolonged storage of household items The storage of large quantities of boxed items within the main living area for an extended period created a significant hazard, particularly for an elderly and potentially vulnerable tenant. (b) Lack of clear controls or time limits There appeared to be no clear policy or instruction governing: • how long household items may be stored within living areas as part of necessary works; or • what mitigating steps should be taken when such storage extends beyond a minimal or short-term period. (c) Risk to other tenants In my view, if similar circumstances were to arise in other properties—particularly those occupied by elderly, disabled or mobility-restricted tenants—there is a risk of future deaths or serious injury arising from restricted movement or trip hazards.
6	ACTION SHOULD BE TAKEN In my view, action should be taken to prevent future deaths, and I believe Sanctuary Housing has the power to take such action.

7	YOUR RESPONSE You are required to provide a written response to this report within 56 days of the date of this report. Your response should set out: • the action taken or proposed to be taken; or • an explanation if no action is proposed.
8	COPIES and PUBLICATION I have sent a copy of my report to the Chief Coroner and the deceased's family. I am also under a duty to send a copy of your response to the Chief Coroner and all interested persons who in my opinion should receive it. I may also send a copy of your response to any other person who I believe may find it useful or of interest. 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.
9	14th April 2026 Mr N Graham Area Coroner for Oxfordshire