West London Coroner Service
25 Bagleys Lane, Fulham, London, SW6 2QA
[redacted]

Date: 10 July 2026
[redacted]

REPORT TO PREVENT FUTURE DEATHS

REGULATION 28 OF THE CORONERS (INVESTIGATIONS) REGULATIONS 2013

1 **CORONER**

I am **Melanie Lee** for **West London**

DATE OF REPORT: 10 July 2026

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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.

http://www.legislation.gov.uk/ukpga/2009/25/schedule/5/paragraph/7

http://www.legislation.gov.uk/uksi/2013/1629/part/7/made

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4 **THIS REPORT IS BEING SENT TO**

1. Aria Care

You are under a duty to respond to this report within 56 days of the date of this report, namely by 4 September 2026. I, the Coroner, may extend the period if an appropriate application is made.

YOUR RESPONSE

5 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.

SUMMARY OF CORONER'S CONCERN

6 Home residents at Deer Park View, including those at high risk of falls, do not have pendant alarms and bathroom emergency cords cannot be reached from the floor if a resident falls.

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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.

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8 **INVESTIGATION and INQUEST**

On 30 January 2026 an investigation was commenced into the death of Joan Marie MURPHY.

The investigation concluded at the end of the inquest .

The conclusion of the inquest was

Accident

The medical cause of death was

1a Bronchopneumonia and Heart Failure (joint causes)

1b Thoracic Fractures following Fall

1c

II Frailty of Old Age, Osteoporosis

CIRCUMSTANCES OF THE DEATH

9 Joan Marie Murphy was a 90 year old lady with a background history of osteoporosis, falls and low blood pressure. After falls at home over Christmas 2025, Joan went for respite at Deer Park View Home in Teddington. On 9 January she suffered a further fall and after calls to the 111 service, she was assessed in person by a clinician. In the morning of 15 January Joan fell in her bathroom. She was unable to reach the emergency call bell due to the position of the alarm cord in the bathroom (hanging from the ceiling). Joan did not have a pendant alarm. After shouting for help, Joan reported pain in her left hip, left leg, lower back and head. Following calls to 999, her GP and the GP covering the care home, and NHS 111, paramedics attended later that day and suspected that Joan had suffered a myocardial infarction. Joan was taken to St George's Hospital where an MI was ruled out but a CT trauma revealed rib fractures. Despite active treatment for pneumonia and pain relief for the fractured ribs, Joan suffered a cardiac arrest and died in hospital on 30 January 2026.

CORONER'S CONCERNS

During the course of the inquest the evidence revealed matters giving rise to concern. In my
10 opinion there is a risk that future deaths will occur unless action is taken. In the circumstances it is my statutory duty to report to you.

The **MATTERS OF CONCERN** are as follows.

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. Despite requests querying this, I did not receive an answer as to why not.

COPIES AND PUBLICATION OF THIS REPORT

11
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:

1. Joan's niece
2. Joan's close friends [redacted]

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.

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10 July 2026

[redacted]

Signature

Melanie Lee

Area Coroner for West London
