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 Sarah WHITBY, HM Assistant Coroner, for the coroner area of Hampshire, Portsmouth and Southampton.
2.	**DATE OF REPORT** 16 July 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** [redacted], **Deputy Director of Adult Social Care, Portsmouth County Council** You are under a duty to respond to this report within 56 days of the date of this report, namely by September 9, 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**

	That a person of impaired cognitive and physical ability was able to access a stairwell and fall down 9 steps.
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 07 August 2025 I commenced an investigation into the death of Sandra Christine MOON aged 65. The investigation concluded at the end of the inquest on 24 June 2026. The conclusion of the inquest was that:
9.	**CIRCUMSTANCES OF DEATH** The deceased Sandra Christine Moon, a resident of the Russets Care Home, Gatcombe Drive, Portsmouth, Hampshire, PO2 0TX, on the 26th July 2026, accessed a stairwell at the home and fell down a flight of nine steps, whilst still strapped in her wheel chair. The reason for her entering the stairwell are unknown, and something she had not done in the previous eleven years of residence. The deceased had some learning difficulties and significant health issues, but was aware of danger. Her ability to enter the stairwell of her own accord are in doubt and is not known if another person opened the stairwell door to enable access. The deceased suffered injuries which made her vulnerable to pneumonia, from which she died as a direct result on the 1st August 2025 at Southampton General Hospital.
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: That a person of impaired cognitive and physical ability was able to access a stairwell in a wheelchair and fall down 9 steps, and the reason for her being able to do so is unclear.
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: • **Portsmouth Council Adult Social Care** • **Brother of Sandra Moon** 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** [redacted] **Sarah WHITBY** **HM Assistant Coroner for** **Hampshire, Portsmouth and Southampton**