HM CORONERS COURT

IN THE MATTER OF THE INQUEST

TOUCHING THE DEATH OF WILLIAM GEORGE RICE

	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS WILLIAM GEORGE RICE deceased, known as William to family and friends
1	**CORONER** **I am Guy Davies, His Majesty's Assistant Coroner for Cornwall & the Isles of Scilly.**
2	**DATE OF REPORT** 10 August 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** 1. [redacted] Chief Executive Officer Cornwall Council 2. [redacted] Managing Director Cornwall Housing Limited You are under a duty to respond to this report within 56 days of the date of this report, namely by 5 October 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** 1. The current terms of the adaptation policy applied by Cornwall Housing Limited do not take account of wider circumstances including the potential risk to life from a refusal to install an adaptation recommended by Cornwall Council social services. 2. There has been no formal multi-agency review of potential risks to life from the application of current CHL policy to future cases with similar facts to William's.
7	**ACTION SHOULD BE TAKEN** In my opinion action should be taken to prevent future deaths and I believe you [AND/OR your organisation] have the power to take such action.
8	**INVESTIGATION and INQUEST** On 31 October 2025 the coroner service commenced an investigation into the death of 91-year-old William. The investigation concluded at the end of the inquest on 15 July 2026. The medical cause of death was established on the evidence as follows: *1a Right Subdural, Subarachnoid, Right Rib Fractures 5-9, Large Right Pleural Effusion, Left Cerebellar Contusion* *1b Fall* *II Frailty* The four questions - who, when, where and how – were answered as follows: *William George RICE died on 22 October 2025 at Royal Cornwall Hospital Treliske Truro from trauma consistent with a fall downstairs on 20 October 2025 at his home address.* *An assessment by adult social services (ASC) led to an urgent request on 13 August 2025 for Cornwall Housing Ltd (CHL) to install a stairlift at William's home address. The urgent request was based upon a serious risk of William falling down the stairs due to significant issues of mobility and balance together with the fact that William needed to be able to safely access the staircase to fulfil caring responsibilities as sole carer for his wife who has dementia.*

	The request for a stairlift was refused on 3 September 2025 by CHL applying the terms of company policy. ASC were not notified of the refusal and only became aware of the fact of the refusal on 16 October 2025 on which date an immediate appeal was lodged. A decision by CHL to authorize the stairlift following the appeal was made on 23 October 2025 as an exception to the policy and unbeknown to the fact that William had fallen downstairs on 20 October 2025 and died on 22 October 2025. The conclusion as to the death was as follows: *William died from catastrophic injuries sustained after falling down the stairs at his home whilst awaiting the outcome of an application process for the installation of a stairlift by Cornwall Housing Limited, this adaptation having been urgently requested by social services over two months before the fatal fall.*
9	**CIRCUMSTANCES OF THE DEATH** The circumstances of William's death are set out in the above answers to the four statutory questions (who, when, where and how). I can add that it was found that if a more flexible policy had been applied (in the initial response to the application for a stairlift) taking account of wider circumstances, the outcome could possibly have been different.
10	**CORONER'S CONCERNS** During the course of the inquest the evidence revealed matters giving rise to concern. In my 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. – William lived in a property owned by Cornwall Council. The decision whether to approve or refuse an adaptation such as a stairlift to Cornwall Council owned property is a matter for Cornwall Housing Ltd (CHL) under its adaptations policy. CHL is a company set up by Cornwall Council to manage and maintain its housing stock. Adult Social Care (ASC) Therapy assessed William's functional needs on 7 August 2025 and recommended the adaptation as being urgently required. ASC drafted and submitted the application for a stairlift on William's behalf. The application to CHL noted that there was a serious risk of William falling down the stairs due to significant issues of mobility and balance together with the fact that William needed to be able to safely access the staircase to fulfil caring responsibilities as sole carer for his wife who has dementia. The application also referred to the fact that William and his wife had lived at the property for 50 years and there was a support network in the locality. In addition to the risk to life there is also an indication that social services would incur significant costs as a result of any refusal of the application due to the need to provide additional social care in the absence of necessary adaptations. The terms of the current adaptations policy do not take account of any of these factors. There are criteria which require applications for adaptations to be refused in all circumstances in which there is under or over occupancy. Williiam lived in a 3-bedroom property occupied by he and his wife. This was deemed to be under occupancy and the application was initially refused on that basis. At Inquest CHL witnesses mainatained that

	this was the correct decision under current policy. Therapists within ASC do not consider the CHL policy adequately addresses risk and wider circumstances. There are practitioners within CHL who consider the adaptations policy to be flawed. The court found that on two occasions the stairlift for Williiam's property had been authorised as an exception to the policy. The evidence from CHL is that these decisions (exceptions being made to policy) were erroneous because there are no exceptions under the terms of the policy. The court found that there has been no formal multi agency review of potential risks to life from strict application of current policy. ASC and CHL have conducted separate reviews leading to learnings which appear focused on communication rather than policy. These reviews and learnings have not addressed the concern of a risk of future deaths from the application by CHL of policy to future cases with similar facts to William's.
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: 1. The family of William George Rice 2. The Service Director for Adult Social Care, Cornwall Council 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.
	SIGNATURE [redacted] **HMC Guy Davies**