Derek Winter DL
Senior Coroner for the City of Sunderland

	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO: -** **Village Nursing & Care Home @ Murton** **Wellfield Rd** **Murton** **Seaham SR7 9HN**
1	**CORONER** I am Derek Winter, Senior Coroner for the City of Sunderland.
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. http://www.legislation.gov.uk/ukpga/2009/25/schedule/5/paragraph/7 http://www.legislation.gov.uk/uksi/2013/1629/part/7/made
3	**INVESTIGATION and INQUEST** On 16th November 2015 I commenced an investigation into the death of Mr Vincent Smith, aged 80 years. The investigation concluded at the end of the Inquest on 1st April 2016. The conclusion of the Inquest was Accident Contributed to by Neglect.
4	**CIRCUMSTANCES OF THE DEATH** Mr Smith was admitted to the Village Nursing and Care Home Murton on 6th November 2015. He had unwitnessed falls on 7th and 8th November, which led to his admission to Sunderland Royal Hospital on 9th November 2015. On 15th November 2015 Mr Smith died from a head injury and bilateral pneumonia.
5	**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. – Whilst at the Village Nursing and Care Home members of staff were to monitor and support Mr Smith's mobilisation. Although being on notice after his first fall, there were insufficient steps taken to assess and act upon Mr Smith's vulnerability.

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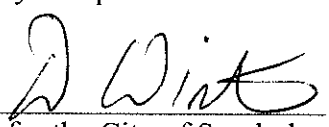
	Evidence suggested that there ought to be: - 1) a review of the Home's formal written admissions policy to include verification of the information provided about the suitability of a prospective resident for admission, as well as 2) a review of the Home's formal written falls risk assessments policy and associated training for staff, together with any other steps that ought to be taken to mitigate the risks of falls.
6	**ACTION SHOULD BE TAKEN** In my opinion action should be taken to prevent future deaths and I believe you have the power to take such action.
7	**YOUR RESPONSE** You are under a duty to respond to this report within 56 days of the date of this report, namely by 4th June 2016. I, the coroner, may extend the period. 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.
8	**COPIES and PUBLICATION** I have sent a copy of my report to the Chief Coroner and to the following Interested Persons: - • Family • CQC I am also under a duty to send the Chief Coroner a copy of your response. 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 by the Chief Coroner.
9	Dated this 6th day of April 2016 Signature  Senior Coroner for the City of Sunderland