




Derek Winter DL
Senior Coroner for the City of Sunderland

	<p style="text-align: center;">REGULATION 28 REPORT TO PREVENT FUTURE DEATHS</p> <p>THIS REPORT IS BEING SENT TO: - Mr Ian D Renwick Chief Executive Gateshead Health NHS Foundation Trust Queen Elizabeth Hospital Sheriff Hill Gateshead NE9 6SX</p>
1	<p>CORONER</p> <p>I am Derek Winter DL, Senior Coroner for the City of Sunderland</p>
2	<p>CORONER'S LEGAL POWERS</p> <p>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</p>
3	<p>INVESTIGATION and INQUEST</p> <p>On 10th August 2016 Mr Derek Wynne Turnbull aged 86 years died at Sunderland Royal Hospital.</p> <p>I concluded the Inquest as part of my investigation on 15th March 2017 recording a conclusion of an Accident. The Cause of Death following Post-Mortem Examination was: -</p> <ul style="list-style-type: none">Ia Bilateral Bronchopneumonia;Contributed to byII Congestive Cardiac Failure; Ischaemic Heart Disease and Hypertensive Heart Disease; Right Subdural Haematoma consequent upon a fall
4	<p>CIRCUMSTANCES OF THE DEATH</p> <p>Mr Derek Wynne Turnbull had been a resident at the ICAR Unit since 1st August and he had a recognised risk of falls. He was on Warfarin.</p> <p>On 9th August 2016 Mr Turnbull was seen by a member of staff at 02:30am. Staff were alerted by an alarm in Mr Turnbull's room that he was mobile at 03:15am and discovered him face down on the floor. His fall was not witnessed. Staff attended to Mr Turnbull's facial injuries and, although he was observed, an ambulance was not requested to take him to hospital until 04:18am.</p> <p>Paramedics attended to Mr Turnbull at 04:35am and transported him to Sunderland</p>

	<p>Royal Hospital Emergency Department by 05:24am.</p> <p>Mr Turnbull had a CT Scan at 05:48am, and at 07:19am he was given Beriplex to reverse the effects of Warfarin.</p> <p>Mr Turnbull had a large acute-on-chronic subdural haemorrhage and surgical intervention was not an option. Mr Turnbull was made comfortable and passed away on 10th August 2016 at 08:15pm.</p>
5	<p><u>CORONER'S CONCERNS</u></p> <p>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.</p> <p>The MATTERS OF CONCERN are as follows: –</p> <p>Mr Derek Wynne Turnbull had a known history of falls, was on Warfarin and had sustained an obvious head injury after an unwitnessed fall, yet it took from 03:15am to 04:18am to summons an ambulance by a 999 call in a case that was to be “stepped up” to hospital in any event. There was no purpose in waiting, given the known scenario.</p> <p>In Mr Turnbull’s case the delay may not have caused or contributed to his death, but in other cases the opportunity for earlier review at the hospital ought to be taken.</p> <p>Policies, procedures and protocols may need to be reviewed in order to ensure that in those cases that are to be stepped up, that the action is taken immediately.</p>
6	<p>ACTION SHOULD BE TAKEN</p> <p>In my opinion action should be taken to prevent future deaths and I believe you have the power to take such action.</p>
7	<p>YOUR RESPONSE</p> <p>You are under a duty to respond to this report within 56 days of the date of this report, namely by 15th May 2017. I, the coroner, may extend the period.</p> <p>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.</p>
8	<p>COPIES and PUBLICATION</p> <p>I have sent a copy of my report to the Chief Coroner and to the following Interested Persons: -</p> <ul style="list-style-type: none"> • Family • Sunderland Royal Hospital • National Institute for Health and Care Excellence (NICE) • Care Quality Commission (CQC) • North East Ambulance Service and their Solicitors <p>I am also under a duty to send the Chief Coroner a copy of your response.</p>

	<p>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.</p>
9	<p>Dated this 16th day of March 2017</p> <p>Signature  Senior Coroner for the City of Sunderland</p>