Derek Winter DL
Senior Coroner for the City of Sunderland

	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO: -** [redacted] **Care Home Manager** **Dairy Lane Care Centre**
1	**CORONER** I am Derek Winter DL, 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 27th August 2017 Mr John Thomas Lambton, known as Tom, aged 88 years, died at Sunderland Royal Hospital. The Inquest, as part of my Investigation, concluded on 13th February 2018, when I recorded a conclusion of Accident. The Cause of Death following Post-Mortem Examination was: - Ia Brain Herniation Ib Raised Intracranial Pressure Ic Subdural Haematoma II Dementia and Warfarin Therapy
4	**CIRCUMSTANCES OF THE DEATH** Tom was admitted to Sunderland Royal Hospital on the 8th of August 2017 following a series of unwitnessed falls/incidents over several days whilst in respite care at Dairy Lane Care Centre. Subsequent radiological Investigations revealed he had sustained a fractured neck of femur (NOF) and had an active subdural haemorrhage. On the morning of Saturday the 5th of August Tom was noted to have a bump to his head. On the evening of Sunday the 6th of August Tom was noted to be asleep in his room. At 8.45 PM he was found lying on the floor between his bedroom and en suite bathroom. Tom was assisted back to his bed by care staff and he requested an ambulance. At lunch time on Monday the 7th of August the GP attended Dairy Lane and examined Tom. On Tuesday the 8th of August at 11.20AM Tom arrived to hospital by ambulance. Tom underwent surgical repair of his NOF fracture, which was uneventful, the subdural haemorrhage was managed conservatively with close monitoring and reversal of his warfarin anticoagulation. He appeared clinically stable for over a week, repeat scans showed no change in the size of the subdural haematoma and he was treated for a minor

	urinary tract infection and delirium. He deteriorated rapidly 18 days post admission with reducing conscious level and episodes of apnoea, attributed to a subdural re-bleed, and subsequently died on 27th August 2017.
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. – (1) Care home staff with no formal medical training made assumptions about Tom's health following a series of falls/incidents (2) Care home staff disregarded Tom's request for an ambulance following the fall (3) There was insufficient communication with the GP about recent events concerning Tom
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 12th April 2018. 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: - • Family • GP • Care Quality Commission (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 14th day of February 2018 Signature_____ Senior Coroner for the City of Sunderland