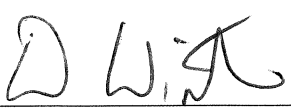
Derek Winter DL
Senior Coroner for the City of Sunderland

	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO: -** [redacted] **Care Home Manager** **Hylton View Care Home**
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 12th November 2017 Mrs Sheila Sullivan Ross (Sheila), aged 86 years, died at Sunderland Royal Hospital. The Inquest, as part of my Investigation, concluded on 14th March 2018, when I recorded a conclusion of Accident. The Cause of Death following Post-Mortem Examination was: - Ia Pelvic Haematoma Ib Fracture Pubic Rami II Chronic Ischaemic Heart Disease
4	**CIRCUMSTANCES OF THE DEATH** Sheila was admitted to Sunderland Royal Hospital on 10th November 2017 following an unwitnessed fall at the Hylton View Care Home. It was initially thought that Sheila had not sustained any serious injury from her fall. However, after care staff had hoisted her into her chair, she began to complain of pain, and an ambulance was called. An x-ray examination showed stable bilateral pubic rami fractures, which were suitable for supportive treatment only via rest and analgesia. Sheila was found to have a urinary tract infection and was treated for urinary sepsis via insertion of urinary catheter, intravenous fluids, oxygen and antibiotics. A pelvic ultrasound scan was ordered to assess her bladder issue. Sheila sadly deteriorated and passed away on 12th November 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 – (1) The falls risk assessment tool used by the Care Home staff appeared to be outdated, and the subsequent level of falls risk recorded by staff was not in keeping with the score generated by the assessment tool. (2) The Care Home buzzer system only allowed one alert mechanism – personal buzzer or sensor mat – to be active at any one time, unless a resident could access the wall buzzer. This can leave residents unable to summon timely assistance when needed. (3) There was poor communication from the Care Home with Sheila's family members, which led them to lose confidence in the standard of care Sheila was receiving.
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 17th May 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 • Sunderland Royal Hospital • 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 19th day of March 2018 Signature  Senior Coroner for the City of Sunderland