

Derek Winter DL Senior Coroner for the City of Sunderland

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	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS
	THIS REPORT IS BEING SENT TO:
	Alexandra 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 11 th June 2020 I commenced an Investigation into the death of Edward Mallaby, who was born on 18 th March 1932 and died on 9 th June 2020, aged 88 years. The Investigation concluded at the end of the Inquest on 9 th December 2020. The conclusion of the Inquest was Accident, the medical cause of death being: - 1a Acute Bronchopneumonia 1b Metastatic Bronchogenic Carcinoma and Vertebral Fractures 1c II Chronic Obstructive Pulmonary Disease
4	CIRCUMSTANCES OF THE DEATH
	Edward Mallaby died at Sunderland Royal Hospital on 9 th June 2020 following his admission with an injury sustained when a boxed television fell onto him in his room whilst residing at Alexandra View Care Home. He became bedbound and his injuries in combination with his underlying health issues led to him developing 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: — 1. There was no clear policy with the handling of residents' personal property which may be hazardous. In particular, if the television could not be immediately fitted or stored securely, then the family should be told to arrange another time for it to be

delivered and/or remove it.

- 2. If a sensor mat was fitted it then it did not activate to alert staff that the deceased was out of bed.
- 3. Staff only discovered the deceased "with the TV Box on the top of his legs" on a routine check rather than by a sensor mat or personal alarm call.
- 4. Although the deceased had a falls risk assessment, it was not clear whether he was subject to hourly or half hourly observations, or whether the door to his room was to be open or not.
- 5. There appeared to be no rapid learning exercise to ensure that other residents were not at any ongoing risk.
- 6. A full review of policy and procedure with associated training was apparently underway but without a deadline for completion.

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 11th February 2021. 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
- Sunderland Royal Hospital
- Care Quality Commission (COC)

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 10th day of December 2020

Signature / / / / Senior Coroner for the City of

Senior Coroner for the City of Sunderland