David Place
Senior Coroner for the City of Sunderland

	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO:** **South Tyneside and Sunderland NHS Foundation Trust**
1	**CORONER** I am David Place, His Majesty's 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 6th February 2025 I commenced an Investigation into the death of Mr Allan Taylor, who died in Sunderland Royal Hospital on 1st June 2024 aged 90 years. The Investigation concluded at the end of the Inquest on 5th March 2025. I gave a narrative conclusion 'Natural causes contributed to by the physiological strain of necessary surgical procedure to a fractured neck of femur following an unwitnessed fall in hospital.' The medical cause of death was: - Ia Myocardial Infarction Ib Hypertension Ic Chronic Kidney Disease II Frailty of Old Age, Fractured Neck of Femur (Operated)
4	**CIRCUMSTANCES OF THE DEATH** Allan was admitted on 28th May 2024 to Sunderland Royal Hospital following an unwitnessed fall at home with a long lie. Upon admission to hospital Allan was assessed as requiring Level 1 EICO observations, and this was upgraded to Level 2 at 19:14hrs on 29th May 2024 due to concerns around Allan's confusion. Allan had been placed in a Side Room 1 due to concerns regarding possible clostridium difficile infection, which was later confirmed positive after tests.

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	Allan had been assessed by a physiotherapist on 29th May 2024 that he needed minimal assistance to mobilise with the assistance of one person and a wheeled Zimmer frame. Allan had an unwitnessed fall on 29th May 2024 at 23:20hrs, with the evidence suggesting that he had moved to the end of his bed to negotiate the bed rails and then walked unaided for approximately 5 metres before falling, resulting in a fractured right neck of femur, which required necessary surgical intervention, as immobility posed a significant risk to him. Noise from his room had alerted a nurse who found him on the floor between the bed and the en-suite bathroom. On 30th May 2024 Allan was moved to an orthopaedic ward in preparation for surgery. Following an uneventful induction of anaesthesia on 1st June 2024, Allan became hypotensive on the operating table and went into a cardiac arrest. Allan passed away whilst in theatre due to the physiological strain of the surgery.
5	**CORONER'S CONCERNS** During the course of the Inquest the evidence revealed a matter 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: – 1. The evidence confirmed that the guidelines for Level 2 EICO observations, which required a nurse to be within sight or sound of Allan, were not complied with as Allan was in a Side Room 1, which was not within sight or sound of the nursing station. It has been explained that the geography of that ward is such that this is the furthest side room away from the nursing station, and a vestibule is before it. 2. The evidence was that this was not escalated to the Matron or Site Manager, which may have resulted in the movement of an additional member of staff to ensure compliance with the EICO Level 2 observations. 3. The evidence was that had Allan been within sight or sound for observations, it was likely that upon Allan attempting to get out of bed, assistance could have been provided to him, which in turn may have prevented the fall. I shall be glad to be told of any learning arising from this death and timescales and results of your review.
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 7th May 2025. 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 • Care Quality Commission 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 11th day of March 2025 Signature:  HM Senior Coroner for the City of Sunderland