David Place
Senior Coroner for the City of Sunderland

	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO:** **NHS North East and North Cumbria Integrated Care Board**
1	**CORONER** I am Abigail Combes, His Majesty's Assistant 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 13th August 2025 I commenced an Investigation into the death of Mrs Oriel Vasey, who died in Sunderland on 5th March 2025 aged 88 years. The Investigation concluded at the end of the Inquest on 16th December 2025. I gave the following narrative conclusion: - Oriel Vasey died on 5 March 2025 at Sunderland Royal Hospital. She had developed a pressure area on her sacrum which deteriorated and resulted in the development of sepsis. This sepsis was treated at hospital but unfortunately caused Oriel's death. The medical cause of death was confirmed as: - Ia. Infected pressure sore Ib. frailty of old age II. Alzheimer's dementia
4	**CIRCUMSTANCES OF THE DEATH** Oriel Vasey was admitted to Regents View Care Home having been detained under s3 of the Mental Health Act and spent a period of time under the care of the Mental Health Trust. As is routine, at the point a person is eligible for discharge from the Mental Health Act, the relevant Integrated Care Board and the Local Authority, are asked to consider the funding and placement arrangements for that person who is eligible for support under s117 of the Mental Health Act 1983. As part of this process a form is completed by the mental health team which identifies what needs that person has.

	In Oriel's case this form had been completed by a nurse, and during the Inquest it became clear that a previous service user's form had been used as the starting point, and unfortunately erroneous information had been left on the form in respect of allergies. The form in Oriel's case therefore retained a reference to a penicillin allergy which was not the case for Oriel. During the Inquest, evidence confirmed that this form was intended purely for the allocation of funding and was not intended to form part of the patient's clinical record. However also in evidence was that in Oriel's case the erroneous information from this form had been added into her clinical record and as a result, when infection was identified, penicillin as the first line antibiotic, was ruled out by doctors treating her. This happened on a number of occasions although in Oriel's case I could find no evidence that this would have changed the outcome for her. Family raised concerns with clinicians that she had previously had penicillin to good effect but the GP was unable to amend the record because this had come from an official source and therefore the risk of amending allergy information on the basis of information from family members was greater than the risk of working on the basis of the allergy information being correct.
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. This form remains in place unchanged, and the process for handling this form, which belongs to the ICB, remains unchanged which means that this same error could occur again. 2. If this form is intended purely for financial decision making, it is unclear why there is a requirement for a specific section on allergies. That has led, in this case, to sub optimal care being provided to Oriel because treating medics had incorrect information on Oriel's clinical record.
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 1st May 2026. 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 and their Solicitors and Counsel • Cumbria, Northumberland, Tyne and Wear NHS Foundation Trust and their Solicitors • South Tyne and Sunderland NHS Foundation Trust • Regents View Care Home and their Solicitors • Hetton Medical Centre and their Solicitors • Care Quality Commission

	I am also under a duty to send the Chief Coroner and all interested persons, who in my opinion should receive it, a copy of your response. The Chief Coroner may publish either or both in a complete or redacted or summary form. She may send a copy of this report to any person who she 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 4th day of March 2026 Signature: [redacted] His Majesty's Assistant Coroner for the City of Sunderland