

Private and Confidential

Ms H Ashley
Chief Executive
Queen's Hospital
Belvedere Road
Burton Upon Trent DE13 0RB

06 February 2014
AAH/

Dear Ms Ashley

Re: Ronald Sidney Ellwood (deceased)

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.

On 28 May 2013 I commenced an investigation into the death of Mr Ellwood aged 76. The investigation concluded at the end of the inquest on 15 August 2013. The conclusion of the inquest was "Complication of medical treatment".

During the course of the inquest the evidence revealed matters giving rise to concern. In my opinion there is a risk that future deaths may occur unless action is taken. In the circumstances it is my statutory duty to report to you.

The MATTERS OF CONCERN are as follows. –

Mr Ellwood died as the result of a chest infection. He had spent several weeks in the intensive care unit (ICU) at Queen's Hospital and I heard helpful evidence from [REDACTED] Clinical Lead for Critical Care about the number of bugs that those with invasive tubes are subject to and the need to treat the bugs that may be causing harm. Mr Ellwood's widow referred to the heat and a lack of fresh air in the ICU. [REDACTED] indicated that the ICU did have air conditioning but he was sympathetic to the suggestion of more fresh air although this was an estates issue. This may have been considered in the past but I wonder if it may be to the benefit rather than detriment of patients in intensive care to have more fresh air (through opened windows) as opposed to recycled air through air conditioning?

In my opinion action should be taken to prevent future deaths and I believe you have the power to take such action. You are under a duty to respond to this report within 56 days of the date of this report, namely by Tuesday 29th October 2013. I may extend the period if required to do so.

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.

I have sent a copy of my report to the Chief Coroner and to the following other persons

- The Chief Coroner
- [REDACTED]
- PFD Reports, The Care Quality Commission
- Mr D Winter, HM Coroner for the City of Sunderland

I am also under a duty to send the Chief Coroner and others interested 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 at the time of your response about the release or the publication of your response by the Chief Coroner.

Yours sincerely

Andrew A Haigh
HM Senior Coroner
Staffordshire (South)