	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO:** **Mrs Helen Ashley, Chief Executive, Queen's Hospital, Burton Upon Trent**
1	**CORONER** I am Mr Andrew Haigh Senior Coroner for the Coroner area of Staffordshire South.
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.
3	**INVESTIGATION and INQUEST** On 5 August 2013 I commenced an investigation into the death of Elsie May Treece aged 95. The investigation concluded at the end of the Inquest on 11 December 2013. The conclusion of the Inquest was accidental death.
4	**CIRCUMSTANCES OF THE DEATH** On 18 July 2013 Mrs Treece had a fall in the care home where she lived, attended Queen's Hospital in Burton and was returned home. On 24 July she had another fall and this time was admitted to Queen's Hospital with a broken arm and an inoperable bleed to her brain. The head injury caused her death at the hospital on 2 August.
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) I received information from the family that on the afternoon of the 26 July 2013, following difficulties in moving Mrs Treece, for a while hospital staff left one of Mrs Treece's daughters (aged 70) supporting her mother. One of them then returned with a blue lifting bag with handles but she was not properly supported and fell back heavily on the bed with some force. Investigation has been carried out by [redacted] the Ward 6 manager and I received a report which indicates there is no record of any such incident either in paper records, electronic records or from speaking to staff on duty. I did not investigate this incident fully because on balance it is unlikely to have been significant so far as the death is concerned. However the view I took on the evidence I did hear was that there had been an incident which should have been reported and may well not have been. I therefore write to you to enquire if staff need to be reminded or may need further training regarding the requirement to report inappropriate incidents even if no major harm seems to come to the patient

	involved. (2) While writing to you perhaps you could also find out for me the reasons why Mrs Treece did not have a CT scan of her head following the attendance on the 18 July 2013. This is not strictly a matter for this formal report but an answer would be appreciated.
6	**ACTION SHOULD BE TAKEN** In my opinion action should be taken to prevent future deaths and I believe you or your organisation 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 10 February 2013. 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: [redacted] – daughter of Mrs Treece, [redacted] – Legal Services Manager, Queen's Hospital and [redacted] – Manager, St Mary's Mount Residential Home. I have also sent it to Mr Derek Winter – HM Senior Coroner for the City of Sunderland and the Care Quality Commission who may find it useful or of interest. 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	**16 December 2013**  Andrew A Haigh HM Senior Coroner Staffordshire (South)