	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO:** **Ms Paula Clarke Chief Executive University Hospitals of North Midlands NHS Trust by email:** [redacted]
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 22 May 2017 I commenced an investigation into the death of Edna Marina Collett aged 82 years. The investigation concluded at the end of the inquest on 23 November 2017. The conclusion of the inquest was 'complication of appropriately prescribed medication'.
4	**CIRCUMSTANCES OF THE DEATH** **Mrs Collett was admitted to County Hospital on 10th March 2017. It was soon established that she could be discharged but needed a suitable care package in the community. There were delays in arranging this. She remained in hospital and died there on 19th May.** **The main factor in her death was a bleed by her brain linked with a medicine she was taking. It is possible that a fall she had on 7th May had been a contributory factor.**
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 **MATTER OF CONCERN** is: **Mrs Collett was in hospital for more than 2 months. For the great majority of that time she did not need to be in hospital and the reason for her being there was that a suitable social placement could not be found for her. You will be well aware of the pressure on hospital beds. Although it may to some extent be out of your control I wonder if you could please look at the existing system to see if there can be improvements in moving patients on from hospital when**

	they are fit to go.
6	**ACTION SHOULD BE TAKEN** In my opinion action should be taken to prevent future deaths and I believe you and/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 23rd January 2018**. 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 namely family members. I have also sent it to Mr Ian Smith HM Senior Coroner for North Staffordshire who may find it useful or of interest. • **Care Quality Commission hsca_compliance@cqc.org.uk** • [redacted] • [redacted] • **Mr I Smith HM Senior Coroner for North Staffordshire** **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	**Date: 28/11/2017** ..... Andrew A Haigh HM Senior Coroner Staffordshire (South) No 1 Staffordshire Place Stafford ST16 2LP Tel No: 01785 276127 Fax No: 01785 276128 www.staffordshire.gov.uk sscor@staffordshire.gov.uk