IN THE WEST YORKSHIRE WESTERN CORONER'S COURT
IN THE MATTER OF:

The Inquest Touching the Death of Gladys May Sayles
A Regulation Report – Action to Prevent Future Deaths

	THIS REPORT IS BEING SENT TO: **Calderdale & Huddersfield NHS Foundation Trust** **Leeds Teaching Hospitals NHS Trust** [redacted] **– Taycare Medical Limited, Unit 2, Royds Close, Leeds.**
1	**CORONER** Martin Fleming HM Senior Coroner for West Yorkshire Western
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 20 of the Coroners (Investigations) Regulations 2013
3	**INVESTIGATION and INQUEST** On 15/10/18 I opened an inquest into the death of **Gladys May Sayles** who, at the date of her death was aged 90 years old. The inquest was resumed and concluded on 9th July 20019 I found that the cause of death to be: - 1a - Fracture of C2 and C3 vertebrae I arrived at a conclusion of Accident
4	**CIRCUMSTANCES OF THE DEATH** At approximately 6.10pm on 26/8/18, Gladys May Sayles was found collapsed with a head and neck injury after an unwitnessed fall in the kitchen of her home address at 40 Close Lea, Rastrick, Brighouse, West Yorkshire. Upon the arrival of paramedics she was taken to Huddersfield Royal Infirmary, where a CT scan revealed that she had sustained fractures to her C2 and C3 vertebrae.

	Although she was subsequently managed conservatively with a hard collar, she deteriorated such that she was discharged for palliative treatment on 3/10/18 to Overgate Hospice, where she succumbed and died on 8/10/18 Although I found that the hard collar did not play any part in the sad death communication and training issues with respect to the use of the hard collar were identified.
5	**CORONER'S CONCERNS** The **MATTER OF CONCERN** is as follows: - • To review the existing guidelines with respect to the use of Aspen collars. • To review training with respect to the application and fixing of the collar in order to make it bespoke to the patient's needs. • To consider the effectiveness of the existing communications between Leeds General neurological unit, Huddersfield Royal Infirmary and the suppliers of the collar's with respect to the fitting of the collar and patients general care.
6	**ACTION SHOULD BE TAKEN** In my opinion action should be taken to prevent future deaths and I believe that Calderdale & Huddersfield NHS Foundation Trust, Leeds Teachings Hospital NHS Trust and Taycare Medical Ltd, has the power to take such action. In the circumstances it is my statutory duty to report to you.
7	**YOUR RESPONSE** You are under a duty to respond to this report within 56 days of its date; I may extend that period on request. Your response must contain details of action taken or proposed to be taken, setting out the timetable for such action. Otherwise you must explain why no action is proposed.

8	**COPIES** I have sent a copy of this report to: • [redacted] – daughter • NHS England • Chief Coroner
9	**DATED this 26th July 2019** **Senior Coroner** MD Fleming **M.D. Fleming**