	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO:** **Gavin Boyle, Chief Executive, University Hospitals of Derby and Burton NHS Foundation Trust, Uttoxeter Road, Derby, DE22 3NE**
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 25 April 2019 I commenced an investigation into the death of Maureen Veronica Martin aged 88 years. The investigation concluded at the end of the inquest on 26 June 2019. The conclusion of the inquest was 'accident' with the cause of death being 'subdural haematoma'.
4	**CIRCUMSTANCES OF THE DEATH** Maureen Martin was admitted to Queens Hospital on 10th April 2019 with cardiac problems. In the early hours of 14th April, while attempting to mobilise by herself on the ward, she fell and sustained a severe head injury. This was not suitable for surgery and it led to her death at the hospital on 19th April.
5	**CORONER'S CONCERN** During the course of the inquest the evidence revealed matters giving rise to a 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 as follows. – Mrs Martin's family were very pleasant and extremely gracious about the circumstances of her death. Her son pointed out that at the time of her fall, the desk for the Nurses' Station on the ward was facing the wrong way. Possibly this was linked to some temporary decoration works. When Mrs Martin's son mentioned this, the desk was repositioned appropriately. I would be grateful if you could check that the desks at Nurses' Stations in Queens Hospital are properly positioned and, if they do temporarily have to be moved, that the best possible visibility is maintained.
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 Monday, 26th August 2019. 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: Mrs Martin's family Aviva Life Services UK Limited Scottish Widows Unit Trust Managers Limited 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	[redacted] ..... Andrew A Haigh HM Senior Coroner for Staffordshire (South) Coroner's Office No 1 Staffordshire Place Stafford ST16 2LP Tel No: 01785 276127 sscor@staffordshire.gov.uk