Private and Confidential

Ms M Oldham
Chief Executive
Stafford Hospital
Weston Road
Stafford ST16 3SA

06 February 2014
AAH/ph/40-13

Dear Ms Oldham

Re: Ethel Smith Leese (deceased)

I am Andrew A Haigh, Senior Coroner for the coroner area of South Staffordshire and 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 9 January 2013 I commenced an investigation into the death of Ethel Smith Leese aged 94. The investigation concluded at the end of the inquest on 7 August 2013. The conclusion of the inquest was accidental death Mrs Leese having died from "1a Intracerebral and subdural haemorrhage 1b Fall and warfarin induced coagulopathy and 2 Fracture left neck of femur and congestive cardiac failure".

Mrs Leese's home address was 67 Summerfield Court, Altona Close, Stone. In November 2012 she had a stroke and broke her pelvis. She was initially admitted to the University Hospital of North Staffordshire but then moved to Stafford Hospital. She was prescribed warfarin for the remainder of her life. From Stafford Hospital she was discharged to a care home in Dunston. On 1 January 2013 she fell at the home and suffered head and leg injuries. She was admitted again to the University Hospital of North Staffordshire where she died on 4 January 2013.

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) There was one matter of concern which relates to the monitoring of Mrs Leese's warfarin levels. The move to the care home required Mrs

Leese to be changed to a different GP practice. The checking by the hospital of Mrs Leese's address (including the address for posting for the yellow booklet) appears to have been fairly chaotic. Her address on the paperwork seems to have remained unchanged, there appears to have been doubt as to whether Cumberland House Medical Practice in Stone or the Penkridge Medical Practice (covering Dunston) were her GPs practice and indeed on one occasion information was sent to the wrong GP practice in Stone (Mansion House). It may be that Mrs Leese was initially considered to be a temporary resident at the care home in Dunston but I wonder if there is a possibility to record addresses better. Possibly this may not just apply in the Haematology Department but in the hospital as a whole. Whilst this may not have been directly relevant in this case it could be significant in other deaths.

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.

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 7 October 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.

I have sent a copy of my report to the Chief Coroner and to the following Interested Persons [redacted] (son), Longridge Care Home at Dunston, [redacted] at Cumberland House Medical Practice in Stone, [redacted] at Penkridge Medical Practice, Mr Derek Winter HM Senior Coroner for Sunderland and The Department of Health, Whitehall, London.

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.

Yours sincerely

Andrew A Haigh
HM Senior Coroner
Staffordshire (South)