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	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO:** 1. **Chief Executive – Queens 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 19 April 2013 I commenced an investigation into the death of Norma Doris Sheppard, 86 years. The investigation concluded at the end of the inquest on 13 March 2014. The conclusion of the inquest was accidental death.
4	**CIRCUMSTANCES OF THE DEATH** On 6th February 2013 Mrs Sheppard fell in the care home where she lived and broke her right hip. She was admitted to Queens Hospital, Burton where she underwent a surgical repair the next day. She has then suffered a stroke and her swallowing has been affected. She was discharged to another care home on 25th March where she died on 10th April from the effects of the fall.
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. – There was considerable confusion about the terms of Mrs Sheppard's discharge from Queens Hospital to the care home on 25 March 2013. There was a written discharge letter that indicated that Mrs Sheppard should continue to receive sub cutaneous fluids at the care home and this presented considerable difficulties in

	finding somewhere suitable to take her. In fact when she was discharged it appears to be on an understanding that she was not going to receive sub cutaneous fluids although this was contrary to the discharge document.
6	**ACTION SHOULD BE TAKEN** In my opinion action should be taken to prevent future deaths and I believe you, the Chief Executive 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 16 May 2014. 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 and family members [redacted] I have also sent it to The Manager's of Mavesyn Ridware Care Home and St Quentin's Nursing Home, Legal Services Manager [redacted] and HM Senior Coroner Sunderland Mr Derek Winter 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	**[DATE]** **[SIGNED BY CORONER]** Andrew A Haigh HM Senior Coroner Staffordshire (South)