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| | **REGULATION 28 REPORT TO PREVENT FUTURE DEATHS**<br><br>**THIS REPORT IS BEING SENT TO:**<br><br>**1. Mr Mark Hackett, The Chief Executive, University Hospital of North Staffordshire NHS Trust, City General, Newcastle Road, Stoke on Trent ST4 6QG**<br>**2.** |
| 1 | **CORONER**<br><br>I am Mr Andrew Haigh Senior Coroner for the coroner area of Staffordshire South |
| 2 | **CORONER'S LEGAL POWERS**<br><br>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**<br><br>On 19 April 2013 I commenced an investigation into the death of Audrey Wakefield aged 82. The investigation concluded at the end of the inquest on 10 April 2014. The conclusion of the inquest was Accidental Death. |
| 4 | **CIRCUMSTANCES OF THE DEATH**<br><br>On 8 January 2013 Mrs Wakefield had a stroke and was admitted to the University Hospital of North Staffordshire (UHNS). She was discharged on 12 January 2013 and on 16 January 2013 moved to live in a care home. On 21 February 2013 she fell at the home, attended Stafford Hospital and was discharged back to the care home. She was then admitted again to UHNS in a poorly condition on 24 February 2013 but deteriorated despite treatment. She moved to Douglas Macmillan Hospice on 10 April 2013 and died there the next day. Death resulted from the effects of the stroke and the fall on 21 February 2013. |
| 5 | **CORONER'S CONCERNS**<br><br>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.<br><br>The **MATTERS OF CONCERN** are as follows. –<br><br>(1) At the Inquest I was greatly assisted by [redacted] Consultant Stroke Physician at your hospital. He indicated that when Mrs Wakefield was discharged from UHNS on 16 January 2013 the communication of relevant discharge information to Mrs Wakefield's GP was not good. The reason was that there is a good communication system from the hospital and GPs in the Stoke on Trent area but this did not apply to more distant practices (Mrs Wakefield's practice was in Stone). [redacted] indicated that steps were being taken to improve this. With |

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| | Stafford Hospital moving to come under the control of your Trust the situation could be quite serious as a number of GPs practices are likely to be involved. It may be that this is being addressed in any event but I should be grateful if you could check that an effective system of discharge information will apply wherever a patient's GP's practice may be situated. |
| 6 | **ACTION SHOULD BE TAKEN**<br><br>In my opinion action should be taken to prevent future deaths and I believe you and your organisation have the power to take such action. |
| 7 | **YOUR RESPONSE**<br><br>You are under a duty to respond to this report within 56 days of the date of this report, namely by Tuesday 17 June 2014. I, the coroner, may extend the period.<br><br>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**<br><br>I have sent a copy of my report to the Chief Coroner and to the following Interested Persons : [redacted] Messrs Weightmans Solicitors, [redacted] at Stafford Hospital, [redacted] UHNS Trust, [redacted] MDU, Mr I Smith HM Coroner for North Staffordshire and to The Care Quality Commission.<br><br>I am also under a duty to send the Chief Coroner a copy of your response.<br><br>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 | **22 April 2014**<br>Andrew A Haigh<br>HM Senior Coroner<br>Staffordshire (South) |