	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO:** **Paula Clark Chief Executive** **University of North Midlands Hospital Trust Royal Stoke University Hospital, Newcastle Road, Stoke-on-Trent, ST4 6QG**
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 13 September 2018 I commenced an investigation into the death of Richard John Lockley aged 72 years. The investigation concluded at the end of the inquest on 8 January 2019. The conclusion of the inquest was 'Trauma from accidental falls exacerbated by delay in suitable feeding' with the cause of death being 'Aspiration pneumonia due to C1/C2 cervical spine fractures'.
4	**CIRCUMSTANCES OF THE DEATH** Mr Lockley had throat and neck cancer. In June 2018 he fell at his home and broke his neck but still could mobilise. On 26th July while attending County Hospital as an outpatient he fell and had to be admitted. He needed to wear a neck collar. He was a complex case and suitable feeding had not been sorted out by the time he died in the hospital on 11th September.
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. – (1) Mr Lockley's condition was a complex one but following discussions it was decided that he should be admitted to a gastroenterology ward at the Royal Stoke University Hospital for a radiologically inserted gastrostomy. Mr Lockley was at County Hospital. There appears to have been very poor communication between County Hospital and Royal Stoke in respect of the transfer. I wonder if this could be improved generally where patients need to be transferred between County Hospital and Royal Stoke. (2) I am always cautious about making reports involving resources but there also appears to have been difficulties in actually finding a gastroenterology bed at

	Royal Stoke for Mr Lockley. I raise this just in case anything can be realistically be done about this.
6	**ACTION SHOULD BE TAKEN** 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** You are under a duty to respond to this report within 56 days of the date of this report, namely by 7th March 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 [redacted] widow of the deceased. I have also sent it to your legal department 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	**...10th January.....2019** ..... Andrew A Haigh HM Senior Coroner for Staffordshire (South) No 1 Staffordshire Place Stafford ST16 2LP Tel No: 01785 276127 sscor@staffordshire.gov.uk