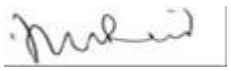
	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO:** [redacted], Chief Executive, Worcestershire Acute Hospitals NHS Trust, Charles Hastings Way, Worcester WR5 1DD;
1	**CORONER** I am David Donald William REID, HM Senior Coroner for Worcestershire.
2	**CORONER'S LEGAL POWERS** 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. http://www.legislation.gov.uk/ukpga/2009/25/schedule/5/paragraph/7 http://www.legislation.gov.uk/uksi/2013/1629/part/7/made
3	**INVESTIGATION and INQUEST** On 31 January 2024 I commenced an investigation and opened an inquest into the death of Margaret Rose MAYCROFT. The investigation concluded at the end of the inquest on 12 September 2024. The conclusion of the inquest was that Ms. Maycroft *"Died from natural causes, to which injuries sustained in a number of recent accidental falls contributed."*
4	**CIRCUMSTANCES OF THE DEATH** In answer to the questions "when, where and how did Ms. Maycroft come by her death?", I recorded as follows: *"On 18.12.23 Margaret Maycroft, who had recently suffered a number of falls at home, which had caused an intracranial bleed, and on a hospital ward during a previous admission, was readmitted to Worcestershire Royal Hospital and found to have suffered an ischaemic stroke. During this admission, she suffered two further falls and was found to have sustained a displaced fractured neck of femur. She underwent surgery to repair this fracture, but thereafter continued to decline. She was transferred to the Princess of Wales Community Hospital, Bromsgrove for palliative care, and declined and died there on 27.1.24."*
5	**<u>CORONER'S CONCERNS</u>** 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) While at Worcestershire Royal Hospital, Ms. Maycroft sustained a number of falls: (a) on 5.12.23 in the Emergency Department; (b) on 19.12.23 in the Emergency Department; (c) on 23.12.23 in the Acute Frailty Unit.

	2) In respect of each of these falls, Matron [redacted] gave evidence that whilst staff in the Emergency Department and the Acute Frailty Unit had completed falls risk assessments, no measures to mitigate that risk, such as might be found in a falls prevention, assessment and intervention plan, were documented in Ms. Maycroft's notes. This meant that no documented falls prevention measures were put in place for her. 3) Furthermore, I heard no evidence at the inquest which satisfied me that steps have now been taken to ensure falls prevention measures are now being properly considered and documented in both the Emergency Department and the Acute Frailty Unit at the hospital.
6	**ACTION SHOULD BE TAKEN** In my opinion action should be taken to prevent future deaths and I believe you, as the Chief Executive of Worcestershire Acute Hospitals NHS Trust 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 **15 November 2024.** 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: (a) [redacted], Ms. Maycroft's nephew. 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	**20 September 2024**  **David REID** **HM Senior Coroner for Worcestershire**