

REPORT TO PREVENT FUTURE DEATHS

REGULATION 28 OF THE CORONERS (INVESTIGATIONS) REGULATIONS 2013

If during an investigation, a coroner becomes concerned about circumstances that create a risk of future deaths, Paragraph 7 of Schedule 5, Coroners and Justice Act 2009, provides coroners with the duty to make reports to a person, organisation, local authority or government department or agency where the coroner believes that action should be taken to prevent future deaths. That report is called a Prevention of Future Deaths Report (PFD report).

The Chief Coroner provides this template to support coroners in the effective and consistent exercise of their statutory duties under the Coroners and Justice Act 2009 and Regulations 28 and 29 of the Coroners (Investigations) Regulations 2013.

The purpose of the template is to provide a clear and structured framework for setting out the matters of concern identified during an investigation which, in the coroner's opinion, give rise to a risk of future deaths. It is designed to promote clarity, ensure that reports are formulated in a way that enables recipients to understand and address the concerns raised, and to support good practice across jurisdictions.

The template does not fetter judicial independence: coroners remain responsible for determining the facts, identifying the matters of concern, and drafting reports that accurately reflect the circumstances of each individual case. The template may be adapted as necessary to ensure that the report properly and precisely records the coroner's views.

In accordance with the Chief Coroner's [PFD Publication Policy \(2026\)](#) any applications for redactions to content or general publication of the report must be sent to the coroner. The coroner will provide the representations to the Chief Coroner for a decision.

	REPORT TO PREVENT FUTURE DEATHS REGULATION 28 OF THE CORONERS (INVESTIGATIONS) REGULATIONS 2013 (Please do not include any living persons' names in this document, in accordance with the Chief Coroner's PFD Publication Policy (2026))
1	CORONER I am Louise Hunt HM Senior Coroner for the coroner area of Birmingham and Solihull
2	DATE OF REPORT 7th May 2026
3	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.
4	THIS REPORT IS BEING SENT TO 1. Department of health and social care 2. Birmingham and Solihull Integrated care board. You are under a duty to respond to this report within 56 days of the date of this report, namely by 2 July 2026. I, the coroner, may extend the period if an appropriate application is made.
5	YOUR RESPONSE 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 a duty to send a copy of your response to the Chief Coroner. In accordance with the Chief Coroner's Publication Policy, you should send me any representations regarding the publication of your response. These representations should be made at the same time as the response is provided. I will pass any representations received to the Chief Coroner for a decision. Please note any links to webpages included in the response will not be checked for sensitive information prior to publication, as the information is already online. The names of those who do not respond to PFD reports are regularly published on the Chief Coroner's webpages Non-responses to Prevention of Future Death (PFD) reports - Courts and Tribunals Judiciary.
6	SUMMARY OF THE CORONER'S CONCERN The inquest heard evidence that patients who suffer from severe dementia who need specialist placements often spend many months in hospital whilst funding and suitable placements are being found. Given the resources available on acute hospital wards this puts these patients at risk as they cannot always be adequately supervised. I am concerned that the lengthy delays in securing funding and finding suitable placements for these most vulnerable patients creates a risk of future deaths and I consider action should be taken.
7	ACTION SHOULD BE TAKEN In my opinion unless action is taken to address the above concerns then there is a significant risk of future deaths and I believe each of you have the power to take such action.
8	INVESTIGATION and INQUEST On 27 November 2025, I commenced an investigation into the death of Elsie Margaret Jones,

	aged 86 Years The medical cause of death was 1a Advanced vascular dementia 1b 1c 1d II Frailty of old age, Fall with left hip fracture(operated) How, when and where - see below Conclusion The investigation concluded at the end of the inquest . The conclusion of the inquest was Died from natural causes contributed to by injuries sustained in a fall
	CIRCUMSTANCES OF DEATH <i>[Please explain the relevant circumstances of the individual's death, ideally this should be in no more than 500 words]</i> Mrs Jones suffered from advanced dementia and was at high risk of falling. On 20/06/25 she was admitted to Birmingham Heartlands Hospital after being found outside her home in an agitated state. She presented with challenging behaviour due to a deterioration in her dementia and was initially admitted to the older persons assessment and decisions unit and later moved to ward 30 on 23/06/25. She was managed with regular observations, blood tests, close supervision, and multidisciplinary input with medical optimisation being achieved by 07 August 2025. She was awaiting discharge to a specialist service. She continued to display challenging behaviour and had a tendency to wander and had several falls in hospital including at times when she had 1:1 supervision. On 01/11/25 at 16.03 she fell whilst mobilising around the ward sustaining a hip fractured which was surgically fixed on 03/11/25. Post operatively the decision was made for her to receive palliative care and she was transferred to Connaught house on 08/11/25 where she died on 16/11/25.
	CORONER'S CONCERNS During the course of the inquest I heard evidence giving rise to concern. In my opinion there is a risk that future deaths could occur unless action is taken. In the circumstances it is my statutory duty to report to you. The MATTERS OF CONCERN are as follows: <i>[250-word statement addressing what circumstances of the death have led to the coroner's concern, and why the coroner thinks the person to whom the report is directed is responsible for taking action to prevent future deaths. This statement must not propose what action should be taken, as coroners cannot make recommendations].</i> The inquest heard evidence that patients who suffer from severe dementia who need specialist placements often spend many months in hospital whilst funding and suitable placements are

being found. Given the resources available on acute hospital wards this puts these patients at risk as they cannot always be adequately supervised. I am concerned that the lengthy delays in securing funding and finding suitable placements for these most vulnerable patients creates a risk of future deaths and I consider action should be taken.

COPIES AND PUBLICATION OF THIS REPORT

I have a duty to send a copy of my report to every interested person who in my opinion should receive it.

I also may send a copy of the report to any other person who I believe may find it useful or of interest.

I can confirm I have sent the report to: *(please do not use individual's names, but instead roles/titles)*

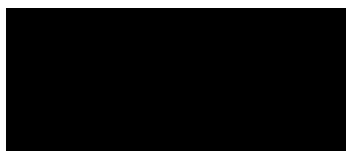
11 1. Mrs Jones's family

2. University Hospital Birmingham NHS Foundation Trust

I also have a duty to send a copy of the report to the Chief Coroner.

You may make representations to me, the coroner, about the publication of the contents of this report in line with Chief Coroner's [PFD Publication Policy \(2026\)](#). Any representations will be sent to the Chief Coroner alongside the report. Please refer to box 4 above for additional information relating to the publication of reports and responses.

SIGNATURE



Louise Hunt

Senior Coroner for Birmingham and Solihull