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 David REID, HM Senior Coroner, for the coroner area of Worcestershire.
2.	**DATE OF REPORT** 24 June 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. The Chief Executive, Worcestershire Acute Hospitals NHS Trust, Charles Hastings Way, Worcester WR5 1DD. You are under a duty to respond to this report within 56 days of the date of this report, namely by August 19, 2026. 1, 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 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 CORONER'S CONCERN** See paragraph [10] below.

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 07 November 2025 I commenced an investigation and opened an inquest into the death of Jacqueline Frances O'BRIEN aged 77. The investigation concluded at the end of the inquest on 24 June 2026. The conclusion of the inquest was that Mrs. O'Brien "died from natural causes, to which injuries sustained in an accidental fall at home contributed."
9.	**CIRCUMSTANCES OF DEATH** Between 17.10.25 and 3.11.25 Mrs. O'Brien was treated at Worcestershire Royal Hospital for head and spinal injuries resulting from an accidental fall down stairs at home. On 3.11.25 she was discharged to Pershore Community Hospital for further rehabilitation at a time when she was becoming increasingly unwell with an intra-abdominal infection, and had to be transferred back to Worcestershire Royal Hospital that same night. Despite treatment, her condition continued to deteriorate, and she declined and died there on the evening of 4.11.25.
10.	**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: On 29.10.25 Mrs. O'Brien's Liver Function Test (LFT) results had been abnormally high (Gamma GT: 545, ALT: 200). The plan was to repeat those tests a few days later. At around 2300hrs on the night of 2.11.25 Mrs. O'Brien was transferred to the Pathway to Discharge Unit (PDU) at Worcestershire Royal Hospital with a view to her discharge for further rehabilitation to Pershore Community Hospital. At the time of her transfer to the PDU, it was recorded in her notes that she had been experiencing gastrointestinal pain for the previous hour, and had passed loose stools. Her LFTs were repeated that morning, and although had lowered, were still considered abnormally high (Gamma GT: 387; ALT: 122). At 1200hrs on 3.11.25 a trauma and orthopaedic doctor recorded that Mrs. O'Brien's discharge could not go ahead because of these still abnormal LFT results. The note continues: "Escalated the problem to the capacity team, and they

	instructed that the discharge will proceed." At 1230hrs it is recorded that Mrs. O'Brien was re-assessed by the doctor and a consultant and "they said the discharge will carry on." It was agreed by the consultant who gave evidence at the inquest, and by the Trust's legal representative, that thereafter between 1230hrs and Mrs. O'Brien's departure for Pershore at 2025hrs that evening, there is no evidence of any further checks or observations being carried out. In fact, when Mrs. O'Brien was seen on the PDU by family members that same afternoon, it was clear to them that she was in a great deal of pain and distress. They raised their concerns with staff on the PDU, who assured them that she was alright. No member of staff appears to have acted on those concerns, and ensured that Mrs. O'Brien was checked. Those who transported Mrs. O'Brien to Pershore reported to staff there that she "had been in pain on transfer". On her arrival at Pershore at 2100hrs, it was clear to staff there and to an out of hours GP who was called to examine her, that she was in severe pain and very unwell, with a National Early Warning Score (NEWS) of 5. An ambulance was called to transfer her back to Worcester, and the paramedics recorded at 0111hrs that her NEWS score had risen to 10. I am therefore concerned at how staff on the PDU at Worcestershire Royal Hospital failed: (a) for some 8 hours to carry out any checks or observations on a patient who was clearly becoming very unwell; and (b) to follow up concerns raised by Mrs. O'Brien's family about her condition on the afternoon/evening of her discharge. I have found, as a matter of fact that, had they not so failed, they were bound to have noticed how unwell she was becoming and her transfer to Pershore would probably not have taken place. This represented a missed opportunity to provide earlier treatment which may have prevented her dying when she did.
11.	**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]* • **Mrs. O'Brien's daughter** 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.

12.	**SIGNATURE**  **David REID** **HM Senior Coroner for** **Worcestershire**