

**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 Deborah LAKIN, HM Assistant Coroner, for the coroner area of Worcestershire.
2.	DATE OF REPORT 28 July 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. Chief Executive of Worcestershire Acute Hospitals NHS Trust Alexandra Hospital Woodrow Drive Redditch Worcestershire B98 7UB You are under a duty to respond to this report within 56 days of the date of this report, namely by September 22, 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 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 Insufficient awareness of staff on the requirements of the 'Stay in the bay' falls prevention initiative and Level 3 observations.
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 12 February 2026 I commenced an investigation and opened an inquest into the death of Rodney Foster STROUD aged 82. The investigation concluded at the end of the inquest on 28 July 2026. The conclusion of the inquest was that: Narrative Conclusion - Natural causes arising from complications following an unwitnessed fall in hospital, in which the deceased suffered a subdural haematoma.
9.	CIRCUMSTANCES OF DEATH Rodney Foster Stroud died on 7 February 2026 at his home address, Driftway Barn, Evesham Road, Evesham, of a urinary tract infection. Mr Stroud had been admitted to hospital in July 2025 following a fall at home, but he suffered an unwitnessed fall whilst in hospital and suffered a subdural haematoma as a result. This, together with his pre-existing comorbidities, including heart failure and atrial fibrillation, compromised his ability to recover from infection.
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: Oral evidence given at the inquest revealed that in the opinion of a senior staff member, there is insufficient awareness of the requirements of the 'Stay in the bay' falls prevention initiative and Level 3 observations, which in their opinion, is a result of insufficient training on the subject.
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: • Daughter of the deceased 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  HM Assistant Coroner for Worcestershire