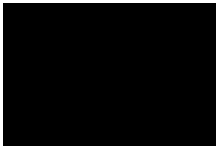


**REPORT TO PREVENT FUTURE DEATHS
REGULATION 28 OF THE CORONERS (INVESTIGATIONS) REGULATIONS
2013**

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 12 August 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 October 07, 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

	Some doctors and nurses at your Trust's hospitals do not understand (a) the importance of maintaining fluid charts for patients with urinary or kidney infections; and (b) the importance of looking for venous thromboembolism (VTE) assessments in patients' notes and acting on them.
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 29 September 2025 I commenced an investigation and opened an inquest into the death of Mathew Charles BAILEY aged 53. The investigation concluded at the end of the inquest on 12 August 2026. The conclusion of the inquest was that Mr. Bailey died from natural causes.
9.	CIRCUMSTANCES OF DEATH On 17.9.25 Mathew Bailey, who lived with a number of significant background medical conditions, including poorly controlled diabetes, was admitted to the Alexandra Hospital, Redditch and treated for a recurrent kidney infection. In the early hours of 22.9.25 he suffered a sudden deterioration and went into cardiac arrest, likely the result of a pulmonary embolus. Despite the prompt administration of advanced life support, he could not be revived, and was confirmed deceased a short time later.
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: The author of your Trust's After Action Review report gave evidence that when the deceased was admitted to the Alexandra Hospital, Redditch on 17.9.25 and treated for a likely recurrence of a kidney infection: (a) charts monitoring his intake and output of fluids should have been started and maintained, but were not. Nurses should do this as a matter of course for any patient with a urinary or kidney infection, and the doctors who reviewed him regularly during his 5 day admission should also have picked up on the fact that his fluids were not being monitored. It is unclear why no fluid charts were started, or why this failure was not spotted; (b) a venous thromboembolism (VTE) assessment was carried out, which identified that the deceased had an identified risk of suffering a VTE event and prescribed compression stockings to mitigate that risk. Both the nurses and doctors looking after the deceased should have picked up on this, but did not, with the result that the deceased was without VTE prophylaxis for the duration of his admission. Whilst it may not have been easy (at the time) for doctors and nurses to find the VTE assessment in the deceased's notes, it is

	concerning that, if it was being looked for and not found, the search was not being followed through. Both (a) and (b) above suggest that some doctors and nurses do not appreciate the fundamental importance of the issues identified.
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 the deceased's next of kin. 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