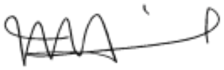
Regulation 28: REPORT TO PREVENT FUTURE DEATHS

NOTE: This form is to be used **after** an inquest.

	REGULATION 28 REPORT TO PREVENT DEATHS **THIS REPORT IS BEING SENT TO:** **1** [redacted] **Chief Executive** **Stepping Hill hospital** **Oak House** **Poplar Grove** **Hazel Grove** **Cheshire** **SK2 7JE**
1	**CORONER** I am Jacqueline DEVONISH, Senior Coroner for the coroner area of Cheshire
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.
3	**INVESTIGATION and INQUEST** On 25 March 2024 I commenced an investigation into the death of Charles Henry DANIELS aged 81. The investigation concluded at the end of the inquest on 29 August 2024. The conclusion of the inquest was that: Natural causes
4	**CIRCUMSTANCES OF THE DEATH** 81 year old Charles Daniels was taken from home to Stepping Hill Hospital arriving at 04:00 hours on 26 January 2024. Family members had noticed a decline in his mobility and responsiveness. He had a significant previous medical history which included rheumatoid arthritis, an active stroke and subarachnoid haemorrhage diagnosed in March 2023. He suffered various falls resulting from that condition over the last year. He had previously attended Stepping Hill with what appeared to be a seizure in August 2023 and had been referred to a Neurologist who tested for motor neurone disease, which was negative. He was due an MRI scan to rule out causes for his confusion at the point at which he was admitted to Stepping Hill Hospital. The complaint on admission was lethargy and bruise to the right side of the head following a fall at home. A CT scan revealed a bilateral new subdural collection due to a malignant process. Given the diagnosis of a bleed the expectation was that it would stop, and it did. His confusion improved. Consequently, in March 2024 he was thought to be optimised for discharge. He did not see a doctor immediately prior to discharge. The records incorrectly indicated that Mr Daniels was completely mobile despite telephone reports to the family that he was deteriorating. He was sent home by ambulance on 6 March 2024 due to being unfit to be transported by car. He was clearly unwell and returned by ambulance to Macclesfield Hospital on 9 March 2024 where a CT scan revealed an acute on chronic subdural bleed. He was transferred to Salford Hospital into the care of the neurosurgical team. His condition was not survivable at any point from 26 January 2024 and he sadly passed away on 21 March 2024. His condition fluctuated in keeping with a rare diagnosis of intracranial hypotension which

	was not known until a specialist neuroradiologist independently reviewed the scans at Stepping Hill following his death.
5	**CORONER'S CONCERNS** During the course of the investigation my inquiries revealed matters 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: (brief summary of matters of concern) 1) Record keeping by the nursing team at Stepping Hill Hospital did not record the fluctuations in presentation relevant to the diagnosis of intracranial hypotension or to enable or confirm a review of his condition prior to discharge. 2) Neither the discharging nurse nor North West Ambulance Service personnel attending Stepping Hill on 6 March 2024, for the purposes of his discharge home, appear to have alerted a doctor to the significant deterioration in Mr Daniel's condition since last assessed by a doctor on 4 March. 3) He arrived home by ambulance to his family in physically poor condition and clearly very unwell, on a stretcher in a hospital gown and incontinent, causing considerable distress to the family, particularly after a nurse, the paramedics and his carer questioned how they would cope with his care at home.
6	**ACTION SHOULD BE TAKEN** In my opinion action should be taken to prevent future deaths and I believe you (and/or your organisation) 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 October 30, 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 Interested Persons [redacted] I have also sent it to **Browne Jacobson solicitors** Who may find it useful or of interest. I am also under a duty to send a copy of your response to the Chief Coroner and all interested persons who in my opinion should receive it. I may also send a copy of your response to any person who I believe may find it useful or of interest. 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	**Dated: 04/09/2024**  **Jacqueline DEVONISH** **Senior Coroner for** **Cheshire**