


REGULATION 28: REPORT TO PREVENT FUTURE DEATHS

	<p>REGULATION 28 REPORT TO PREVENT FUTURE DEATHS</p> <p>THIS REPORT IS BEING SENT TO:</p> <p>The CEO, Stockport NHS Foundation Trust</p>
1	<p>CORONER</p> <p>I am Andrew Bridgman, Assistant Coroner, for the coroner area of Manchester South</p>
2	<p>CORONER'S LEGAL POWERS</p> <p>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</p>
3	<p>INVESTIGATION and INQUEST</p> <p>On 12.03.25 an inquest was opened into the death of Audrey Newman who died at Stepping Hill Hospital on 24 November 2024. The inquest concluded on 22.08.25. The investigation concluded on 03.02.23.</p> <p>1a) Renal failure 1b) Acyclovir treatment 1c) Encephalopathy of unknown cause</p> <p>The conclusion was one of Died from recognised risks of antiviral therapy for a suspected life-threatening condition.</p>
4	<p>CIRCUMSTANCES OF THE DEATH</p> <p>Audrey Newman was admitted on the evening of 10 November 2024 following a seizure at home. The working diagnosis was a suspected encephalitis and in accordance with guidelines treatment with antibiotics and antivirals (acyclovir) was commenced that evening. A lumbar puncture was planned for 11 November 2024 as part of the diagnostic pathway. It was not carried out, according to the Trust's Lessons Learned Overview, because there was a lack of competent ward doctors to carry out such a procedure, especially for a patient as AN who was agitated and confused. A lumbar puncture was eventually carried out on 18 November 2024 by the anaesthetic team - it was negative. The Trust also acknowledge in its LLO that delay occurred because no one consultant took ownership of the need and arrangements for the lumbar puncture. On the pathological evidence, and that the lumbar puncture on 18 November was negative and that the Trust's witness talking to the LLO was not able to provide a rationale as to why the Trust felt that had a lumbar puncture been carried out on 11 November it would have been positive – the inquest determined that had a lumbar puncture been carried out on 11 November 2024 it would likely have been reported, within 24hrs, as negative and the antiviral and antibiotic treatment stopped sometime on 12 November 2024.</p> <p>Antiviral (and antibiotic) treatment continued on 12, 13, 14, 15 and 16 November 2024, albeit on a decreasing dosage from 13 November as there were concerns about diminishing renal function; a recognised complication of acyclovir. By 17 November 2024 AN had developed severe renal failure which did not respond to treatment. No clinical or pathological cause was found for the presenting encephalopathy, namely the seizure and low conscious level; it is unlikely to have been infective encephalitis. It was not possible to determine whether or not, had the antiviral and antibiotic treatment been stopped on 12 November 2024, AN would not have progressed to severe renal failure.</p>
5	<p>CORONER'S CONCERNS</p>

	<p>The evidence of the Trust was that CSF analysis was CRUCIAL for diagnosing meningitis or encephalitis when infection is suspected. Further, acyclovir is well recognised as a drug giving rise to renal injury.</p> <p>In its LLO the Trust stated that, in recognition of the lack of training to enable ward doctors to undertake lumbar puncture a series of training sessions were held and are to continue.</p> <p>Within the LLO it is stated, <i>There is learning in relation to escalation by doctors when a lumbar puncture is needed and hasn't been done either due to difficulty (eg agitation) or unavailability of competency trained doctors. This has been discussed and case shared at the general medicine teaching sessions in April 2025.</i></p> <p>The witness speaking to the LLO said that requests for escalation are still informal and based on goodwill. There is no formal process for requesting assistance.</p> <p>The issue of concern is that in the absence of a formal pathway or referral process to the anaesthetic team for those cases which fall into the above category there is a significant risk of future delays in carry out crucial diagnostic tests, and a risk of death.</p>
6	<p>ACTION SHOULD BE TAKEN</p> <p>In my opinion action should be taken to prevent the risk of future deaths and I believe you have the power to take such action.</p>
7	<p>YOUR RESPONSE</p> <p>You are under a duty to respond to this report within 56 days of the date of this report 24th October 2025. I the coroner, may extend the period.</p> <p>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.</p>
8	<p>COPIES and PUBLICATION</p> <p>I have sent a copy of my report to the Chief Coroner and to the following Interested Persons namely Mrs Newman's family, who may find it useful or of interest.</p> <p>I am also under a duty to send the Chief Coroner a copy of your response.</p> <p>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.</p>
9	<p><u>Andrew Bridgman</u> <u>HM Assistant Coroner</u></p>  <p><u>29/08/2025</u></p>