



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, Bradford Teaching Hospitals NHS FT
1	CORONER I am Peter Merchant, Assistant Coroner, West Yorkshire (Western) jurisdiction
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 02 April 2025 I commenced an investigation into the death of Alan HORROCKS aged 72. The investigation concluded at the end of the inquest on 23 October 2025. The conclusion of the inquest was that: Alan Horrocks died at the Bradford Royal Infirmary on 17 March 2025. He had been admitted to hospital on 19 February 2025. Reflecting his presentation and initial investigations until the 24 February 2025 he was treated for a suspected stroke. From 24 February 2025 onwards and reflecting further investigations, the diagnosis changed to one of encephalitis. Ongoing investigations and treatment were given on the basis it was unclear if this was a viral or auto-immune encephalitis, the later by the prescription of steroids, Dexamethasone until 6 March 2025 when further investigations had identified a viral encephalitis. Thereafter, treatment for auto- immune encephalitis was tapered off. On 15 March 2025 Mr Horrocks was noted to have deteriorated with a NEWS score of 12. Investigations identified aspiration pneumonia and Mr Horrocks was in a Hyperosmolar Hyperglycaemic state. Mr Horrocks deteriorated further in that on 17 March 2025 he had an upper gastro-intestinal haemorrhage from the pyloric region. Despite ongoing treatment, Mr Horrocks continued to deteriorate and following the withdrawal of treatment on 17 March 2025, his death was confirmed at 16.33 hours that day.
4	CIRCUMSTANCES OF THE DEATH Alan Horrocks had been admitted to hospital on 19 February 2025. Reflecting his presentation and investigations undertaken, he was initially diagnosed with a suspected stroke. However, by 24 February 2025, again reflecting his presentation and further investigations, principally a further CT scan, the diagnosis was changed to one of encephalitis. He was commenced on treatment for both viral and auto-immune encephalitis until 6 March 2025 when a confirmed diagnosis of viral encephalitis was made. His treatment for viral encephalitis continued whilst that for auto immune encephalitis was tapered off. Late on the evening of 14 March 2025, observations undertaken identified a NEWS score of 5. By shortly before midday on 15 March 2025, following another set of observations his NEWS score had increased to 12. A medical review and investigations at this point identified Mr Horrocks to be in a Hyperosmolar Hyperglycaemic State (HHS). He was transferred to the intensive Care unit and commenced on treatment. By 17 March 2025 his condition had deteriorated further. Investigations by way of a further CT scan identified an active upper GI haemorrhage from the pyloric region. Following discussions with Mr Horrocks family, treatment was withdrawn and his death was confirmed at 16.33 hours that



	day.
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: Following Mr Horrocks death an investigation was undertaken by the hospital, the report in respect thereof being provided to the court late on the afternoon 22 October 2025. The hospital investigation identified inter alia that observations were not completed on the ward overnight on 14 March 2025 in accordance with escalation guidance with no documented reason. Whilst the evidence did not identify Mr Horrocks "baseline" NEWS score, evidence at the inquest hearing from consultants involved in Mr Horrocks care identified a NEWS score of 5 required further observations and possible escalation. Further, that it was likely that there was an ongoing deterioration from late on 14 March 2025 into 15 March 2025 which was only appreciated when further observations were undertaken shortly before midday on 15 March 2025 identifying an increase in the NEWS score to 12. The evidence indicated however that in Mr Horrocks case, even if his deterioration had been identified sooner, on a balance of probabilities, it would not have avoided his death when it occurred. The hospital investigation also identified that during this period the ward bed capacity had been increased from 27 to 33 beds owing to winter pressures with no corresponding change to the nursing establishment on the ward. Further, during this period there were gaps in the existing nursing establishment on the ward. Whilst the hospital investigation had identified these matters, there were no recommendations that these were issues for wider learning or how, if at all, these issues were to be addressed.
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 December 22, 2025. 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 I have also sent it to CQC North West Yorkshire Integrated Care Board 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: 28/10/2025  Peter MERCHANT HM Assistant Coroner for West Yorkshire Western Coroner Area