REGULATION 28 REPORT TO PREVENT FUTURE DEATHS

THIS REPORT IS BEING SENT TO: The Chief Executive, Pennine Care NHS Foundation Trust

CORONER

I am Chris Morris, Area Coroner for Greater Manchester (South).

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.
http://www.legislation.gov.uk/ukpga/2009/25/schedule/5/paragraph/7
http://www.legislation.gov.uk/uksi/2013/1629/part/7/made

INVESTIGATION and INQUEST

On 1st May 2025, an inquest was opened into the death of Derek Crowther who died on the Saffron Unit, The Meadows, Stockport on 16th December 2024, aged 86 years. The investigation concluded with an inquest which I heard on 7th – 8th October 2025.

A post mortem examination determined Mr Crowther died as a consequence of:

1)a) Intracranial Haemorrhage

b) Cerebral Amyloid Angiopathy

At the end of the inquest, I recorded a conclusion of Natural Causes.

CIRCUMSTANCES OF THE DEATH

Mr Crowther died on 16th December 2024 on the Saffron Unit, The Meadows, Stockport as a consequence of complications arising from Cerebral Amyloid Angiopathy. Mr Crowther had been admitted to the Unit for a period of assessment following a profound deterioration in his dementia.

CORONER'S CONCERNS

During the course of the inquest the evidence revealed matters giving rise to concern. In my opinion there is a risk that future deaths will occur unless action is taken. In the circumstances it is my statutory duty to report to you.

The **MATTERS OF CONCERN** are as follows. –

1. The Court heard evidence that a registered nurse working on the Unit at the time of Mr Crowther's death was not up to date with Intermediate Life Support ('ILS') training, despite this being termed 'mandatory'. Having heard evidence from the Trust's Clinical Excellence Lead for Older Peoples' Services, I am concerned that instances continue to arise across the Trust whereby clinical staff are undertaking shifts despite not being up to date with the required level of Life Support training.

2. Whilst the Court heard evidence as to relevant changes made to the Trust's Observations Policy since Mr Crowther's death, I am concerned that despite having an Electronic Patient Records system, there is currently no mechanism in use on the wards for contemporaneous digital recording of observations. I am concerned that an ongoing risk of future deaths arises from this position, in the view of the potential for such systems to accurately record timings of observations, facilitate trend analysis (particularly in the context of a deteriorating patient), and reduce the potential for errors, either arising from incorrect / unclear manual recording of observations

ACTION SHOULD BE TAKEN

In my opinion action should be taken to prevent future deaths and I believe you and your organisation have the power to take such action.

YOUR RESPONSE

You are under a duty to respond to this report within 56 days of the date of this report, namely by **4th December 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.

COPIES and PUBLICATION

I have sent a copy of my report to the Chief Coroner, together with members of Mr Crowther's family and the Care Quality Commission who may find the report to be useful or of interest.

The Chief Coroner may publish either or both in a complete or redacted or summary form. She 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.

Dated: **9th October 2025**

Signature: [redacted], Area Coroner, Manchester South.