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| | **REGULATION 28 REPORT TO PREVENT FUTURE DEATHS**<br><br>**THIS REPORT IS BEING SENT TO:**<br><br>1. Choice Support<br>2. Care Quality Commission |
| 1 | **CORONER**<br><br>I am Joanne Kearsley Area Coroner, for the Coroner Area of Manchester South. |
| 2 | **CORONER'S LEGAL POWERS**<br><br>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**<br><br>On the 7th February 2013 I commenced an investigation into the death of Russell James Felstead date of birth 04.12.1959. The investigation concluded at the end of the inquest on 07.01.2014. The conclusion of the inquest having heard the evidence was an open conclusion. |
| 4 | **CIRCUMSTANCES OF THE DEATH**<br><br>Mr Felstead had severe learning disabilities. He was unable to talk and communicate and required a high level of support and care. He lived in a purpose built home with three other residents and Choice Support provided the supported living needs of the residents. Mr Felstead required the highest degree of care and support. In addition to his learning difficulties he had a diagnosis of epilepsy for which he was prescribed medication. He was not known to have had a seizure for approximately four years. As part of his disabilities Mr Felstead was unsteady and was prone to falls, in addition if sat on the floor he was regularly known to throw himself on the ground. In order to try and prevent injury to his head, a helmet had been purchased which he wore all the time except when bathing.<br><br>On the 7th January 2013 Mr Felstead was found in his room on the floor, unresponsive. The carer on duty telephoned an ambulance. The information passed to the Ambulance Service and subsequently on to the Emergency Department of Stepping Hill Hospital was that Mr Felstead |

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| | had had a seizure. In evidence the carer indicated that this is what he had thought had happened. However the evidence from the Ambulance Service was that it was clearly indicated to them by the carer that a seizure had actually occurred.<br><br>Mr Felstead was taken to Stepping Hill Hospital; no-one attended the hospital with him.<br>In addition, specific medical documents which should have gone with Mr Felstead in the event of any hospital admission were not handed over. This document provided information as to his general medical condition and demeanour.<br><br>Later in the day on the 7th January another Carer attended the hospital and took Mr Felstead's helmet and provided further information to the hospital as to his general behaviour and difficulties. By 19.50 it was recorded in the Nursing notes that Mr Felstead was prone to falls and that he wore a helmet.<br><br>It was not until the 11th January that this information was noted by the doctors at which stage an urgent CT scan was requested which showed the presence of a subdural haematoma. The deceased was transferred to Salford Royal Hospital where he was operated on. He died on the 28th January 2013. |
| 5 | CORONER'S CONCERNS<br><br>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.<br><br>The MATTERS OF CONCERN are as follows. –<br><br>1. There was a failure to provide accurate information to the Ambulance Service<br>2. There was a failure to ensure all appropriate and essential medical documents were handed over and went to the hospital with Mr Felstead.<br>3. There was a failure to accompany Mr Felstead, who was an individual who was unable to communicate, to hospital. I heard in evidence that the lack of information was a difficulty for the treating doctors in the Emergency Department who had no information as to the frequency of seizures, whether he was someone who generally came round from seizures quickly, or whether the Glasgow Coma Score they were recording was what would have been normal for Mr Felstead given his disabilities. |
| 6 | **ACTION SHOULD BE TAKEN**<br>I believe that this level of information should be mandatory in all Care establishments and in my opinion action should be taken to prevent future |

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| | deaths and I believe your organisation, has the power to take such action. |
| 7 | **YOUR RESPONSE**<br><br>You are under a duty to respond to this report within 56 days of the date of this report, namely by 11th March 2014. I, the coroner, may extend the period.<br><br>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**<br><br>I have sent a copy of my report to the Chief Coroner and to the following Interested Persons, namely the family of the deceased, Stepping Hill Hospital and the Coroners' Society Website.<br><br>I am also under a duty to send the Chief Coroner a copy of your response.<br><br>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 | **14 January 2014** **Joanne Kearsley**<br>**HM Area Coroner** |

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| | **REGULATION 28 REPORT TO PREVENT FUTURE DEATHS**<br><br>**THIS REPORT IS BEING SENT TO:**<br><br>Chief Executive, Stepping Hill Hospital |
| 1 | **CORONER**<br><br>I am Joanne Kearsley Area Coroner, for the Coroner Area of Manchester South. |
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| 5 | CORONER'S CONCERNS<br><br>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.<br><br>The MATTERS OF CONCERN are as follows. –<br><br>Doctors must ensure that all relevant information is accessed and read even if this is in the Nursing notes as opposed to the Clinical records. It is clear that the information which prompted an urgent CT scan on the 11th January had been available in Mr Felstead's medical records since the 7th January and his helmet had in fact been at the hospital. |
| 6 | **ACTION SHOULD BE TAKEN**<br>I believe that this level of information should be mandatory in all Care establishments and in my opinion action should be taken to prevent future deaths and I believe your organisation, has the power to take such action. |
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| 9 | **14 January 2014** **Joanne Kearsley**<br>**HM Area Coroner** |