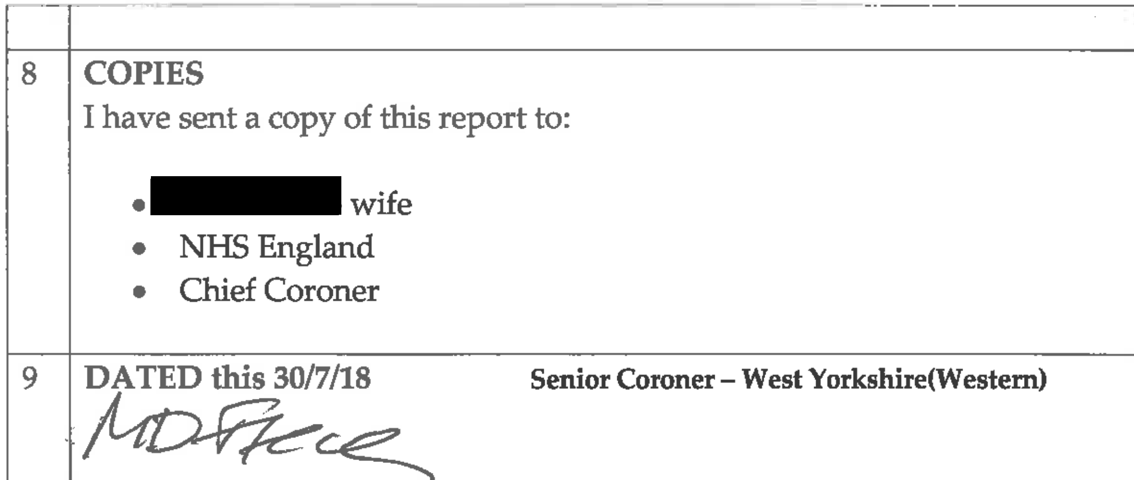
IN THE WEST YORKSHIRE WESTERN CORONER'S COURT
IN THE MATTER OF:

The Inquests Touching the Death of Stanford Shirley Bell
A Regulation Report – Action to Prevent Future Deaths

	THIS REPORT IS BEING SENT TO: Mr Brendan Brown, CEO Airedale NHS Foundation Trust [redacted] **– Riverview Nursing Home**
1	**CORONER** Martin Fleming HM Senior Coroner for West Yorkshire Western
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 20 of the Coroners (Investigations) Regulations 2013
3	**INVESTIGATION and INQUEST** On 16/3/18 I opened an inquest into the death of **Stanford Shirley Bell** who, at the date of his death was aged 82 years old. The inquest was resumed and concluded on 30/7/18 I found that the cause of death to be: - 1a Status epilepticus 1b Acute on chronic subdural haematoma 1c Traumatic head injury II Alzheimer's dementia and type 2 diabetes mellitus I arrived at a conclusion of Accident
4	**CIRCUMSTANCES OF THE DEATH** Mr Stanford Shirley Bell who was diagnosed with dementia, had fall at Riverview Nursing Home, Stourton Road Ilkley on 22/2/18. Upon his admission to Airedale Hospital he was found to have sustained a laceration to his upper lip and several broken teeth. After treatment and a neurological assessment he was discharged back to his care home.

	Subsequently after suffering several seizures throughout the early morning, his GP attended and after examination immediately referred him back to Airedale Hospital where a CT head scan revealed that he had suffered an acute on chronic subdural haematoma to which he succumbed and died on 2/3/18. It was found more likely than not that he sustained the acute subdural haematoma as a result of his fall at the care home on 22/2/18. During the evidence I heard that Mr Bell was discharged from the hospital without discharge papers and that no written reference was made to recommendations about neurological observations. I also heard that during the early morning of 23/2/18 Mr Bell suffered several seizures at the care home and that there was a lost opportunity for the care home to refer him earlier to hospital for the treatment of his seizures, although earlier referral would not have affected the outcome.
5	**CORONER'S CONCERNS** The **MATTER OF CONCERN** is as follows: - • For Airedale Hospital to review procedures at hospital discharge with respect to patients neurologically assessed with head injuries given the absence of discharge papers • For Riverview Care home to review procedures at the care home with respect to referral to hospital of patients suffering from seizures after a recently sustained head trauma.
6	**ACTION SHOULD BE TAKEN** In my opinion action should be taken to prevent future deaths and I believe Airedale NHS Foundation Trust and Riverview Nursing Home has the power to take such action. In the circumstances it is my statutory duty to report to you.
7	**YOUR RESPONSE** You are under a duty to respond to this report within 56 days of its date; I may extend that period on request. Your response must contain details of action taken or proposed to be taken, setting out the timetable for such action. Otherwise you must explain why no action is proposed.



8	**COPIES** I have sent a copy of this report to: • [redacted] wife • NHS England • Chief Coroner
9	**DATED this 30/7/18** **Senior Coroner – West Yorkshire(Western)**