M. E. Voisin
Her Majesty's Senior Coroner
Area of Avon

1st April 2019 REF: 8036

	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO:** **James Scott** **Chief Executive** **Royal United Hospital** **Bath**
1	**CORONER** I am M E Voisin Senior Coroner for **Area of Avon**
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. http://www.legislation.gov.uk/ukpga/2009/25/schedule/5/paragraph/7 http://www.legislation.gov.uk/uksi/2013/1629/part/7/made
3	**INVESTIGATION and INQUEST** On 25/10/2017 I commenced an investigation into the death of Alexander Frederick Richard GREEN. The investigation concluded at the end of the inquest 29th March 2019. The conclusion of the inquest was Accident contributed to by neglect
4	**CIRCUMSTANCES OF THE DEATH** Alexander Green died on 3rd October 2017 at Southmead Hospital, Westbury-on-Trym, Bristol. On 30th September 2017 he was out for a night socialising with friends and was seen to fall. Around 1 hour later at 03.59hrs an ambulance was called when Alex was found lying in the road by passers-by. He was taken Royal United Hospital, Bath and was handed over as intoxicated; his Glasgow Coma Score was 13/15 but he was not seen until 07.20hrs by a doctor who did not diagnose his head injury. Instead Alex was handed over as intoxicated. Alex was not reviewed again that morning by a doctor. At 14.05hrs he suffered a respiratory collapse; a significant head injury was diagnosed which included a fractured skull and haematoma. He was transferred to Southmead Hospital where he underwent treatment; but due to the delay in diagnosis and transfer the treatment provided was futile. He died due to the injuries he suffered in a fall.

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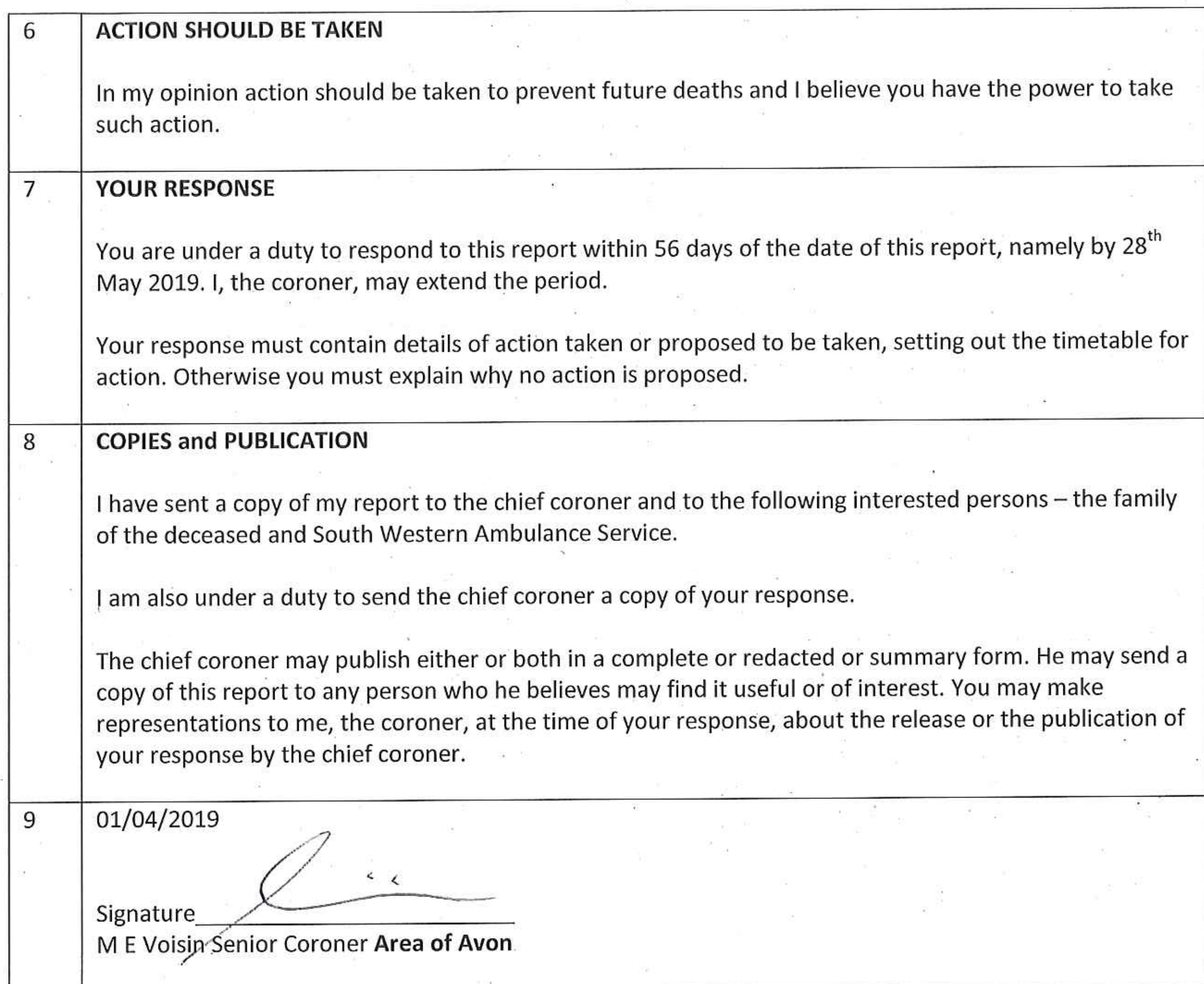
5	**CORONER'S CONCERNS**
	During the course of the inquest the evidence revealed matters giving rise to concern. In my opinion there is a risk that future deaths will occur unless action is taken. In the circumstances it is my statutory duty to report to you. The **MATTERS OF CONCERN** are as follows. – 1. The handover at around 8am resulted in a failure to challenge and communicate effectively. Handovers need to be considered across the whole of the trust not just the emergency department to ensure they are appropriate and effective. The reason I include this as a trust wide matter of concern is that I have recently dealt with another case where there were failures in the handover on another ward at the Royal United Hospital. I have been advised that other hospitals use the SBAR tool at handovers to assist in communication. 2. The NICE guideline for head injury was not considered appropriate for use in this case when it is clearly designed for exactly this case – you ascribe depressed conscious level to intoxication only after a significant brain injury has been excluded. 3. There was an assumption by everyone managing Alex that he was intoxicated when in fact he had a significant head injury; SWAST I am told have developed training in relation to bias (and intoxication is included in that).



6	**ACTION SHOULD BE TAKEN** In my opinion action should be taken to prevent future deaths and I believe you 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 28th May 2019. 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 – the family of the deceased and South Western Ambulance Service. I am also under a duty to send the chief coroner a copy of your response. 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	01/04/2019 Signature____________________ M E Voisin Senior Coroner **Area of Avon**

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