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

13th March 2019 REF: 8772

	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO:** 1. **Royal United Hospital, Bath** 2. **Accountable Office, BANES CCG**
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 04/07/2018 I commenced an investigation into the death of Marcie Joan TADMAN. The investigation concluded at the end of the inquest 12th March 2019. The conclusion of the inquest was Natural Causes Contributed to by Neglect
4	**CIRCUMSTANCES OF THE DEATH** Marcie Tadman died on 5th December 2017 at Royal United Hospital, Combe Park, Bath. She had been admitted to hospital on 4th December 2017 with pneumonia and parapneumonic effusion. She was not referred to the regional unit for treatment of this condition. She had sepsis and there was a failure to recognise and to manage and/or treat sepsis. There were failures to follow the procedures and protocols set nationally or by the hospital. The communication each and every time when discussing Marcie between members of the team was unsatisfactory. All handovers failed to take the opportunity to review Marcie with fresh eyes. The combination of: poor communication between all staff caring for Marcie; the failure to follow any hospital protocols; the lack of proactive review and poor decision making came together to contribute to her death. The medical cause of death: 1a Disseminated group A streptococcal infection including empyema, bronchopneumonia and pyelonephritis

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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. – RUH • I heard from the independent expert Dr. Ninis that the only opportunity for Marcie to be picked up with fresh eyes would have been at another ward round. I understand that this would be an opportunity for a Consultant to take a step back and review the notes, charts, PEWS and results; examine the patient and to make a plan. In Marcie's case everyone agreed that all of the information was there in her records but no one carried out this exercise; there was and is no second ward round on the paediatric ward at the RUH. I indicated to the RUH that I had received further information from [redacted] in relation to a second ward round and this is attached. Accountable Offices for BANES CCG • I was also made aware at the inquest that there is no High Dependency Unit (HDU) facility on the RUH paediatric ward for children in their care and this was something that they were hoping to provide but needed to create a business case to the Accountable Offices for BANES CCG for this. In Marcie's case she should/would have been placed in such a unit had one been at the RUH at the time.

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 – family, [redacted] and to the LOCAL SAFEGUARDING BOARD (where the deceased was under 18)]. 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**