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

13 June 2024 REF:

	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO:** Royal College of Nursing 20 Cavendish Square London W1G 0RN
1	**CORONER** I am M. E. Voisin HM Senior Coroner for 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 17/1/23 an investigation was commenced into the death of Harry Roland Ian Vass. The investigation concluded at the end of the inquest 3-13 June 2024. The conclusion of the jury inquest was a narrative which read as follows: "*On the basis of the evidence presented concerning the events of the morning of 26th December 2022, it is probable that the failure to act at that time contributed to the death of Harry, by delaying his transfer to a hospital environment or place of safety.* *In relation to Harry's medical treatment in the Emergency Department of Southmead Hospital, prior to his transfer to the Mason Unit, the medical evidence deemed him to be medically fit for discharge, at that time. However, it is probable that the failure to take more physical observations, specifically after he had ingested more cocaine and prescribed medication, significantly contributed to the death in that the evidence for his discharge was more likely than not to have been insufficient.*

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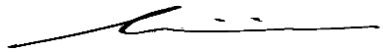
	Given the evidence regarding his treatment in the Mason Unit, it is probable that the failure to perform adequate observations, both physical and non-contact, contributed to Harry's death as, by failing to prioritise the accurate monitoring of his physical condition and therefore identify it's deterioration, an opportunity to transfer him promptly back into the Emergency Department was missed." The medical cause of death was recorded as: **1a) Sudden death, most likely as a result of terminal cardiac arrhythmia, on a background of psychosis and recent cocaine use leading to an acute disturbance in behaviour and complex disturbance in normal physiology**
4	**CIRCUMSTANCES OF THE DEATH** Harry Vass was a 24yr old, he had a history of ADHD, poor mental health, psychosis, paranoia secondary to recreational drug use and illicit drug dependency including cocaine. Harry attended the A&E department of Southmead Hospital on 26th December 2022 at 16.42hrs, with the reason recorded as "mental health", he was expressing paranoid thoughts. He had a high heart rate and was sweating. He underwent a physical assessment and was assessed by the Mental Health Team. At some point he took cocaine in the toilet of the hospital after which he became more agitated and there were concerns being raised that others in the department felt threatened. At one point he absconded from the unit but was brought back, a doctor in the emergency department gave him medication to calm him down. The police were called but when they attended Harry was calm from the effects of the medication. The police were called and attended again when Harry's agitation increased. It was during this discussion that the police officer raised the possibility of Harry having ABD (acute behavioural disturbance). The police officer said that he'd seen close to a dozen cases, that Harry had similar symptoms. The two mental health practitioners said that they knew very little about ABD. After some discussions with the police officer, the two mental health practitioners and the consultant in emergency medicine Harry was deemed medically fit and he was admitted under s136 Mental Health Act to The Mason Unit (a place of safety) within the hospital at around 23.00hrs. Once on the Mason Unit Harry continued to be distressed and agitated, he was given further medication to calm him. Harry remained disturbed but had periods of calm, he became fearful of isolation, he became sleepy and at around 3.30hrs on 27th December 2022, he vomited. Observations were carried out confirming that Harry had low oxygen saturations and a high temperature. At 4.45hrs his extremities were discolouring, and he became unresponsive, an ambulance was called. He was transferred back to the A&E department but died at 06.36hrs.

	Dr Delaney a forensic pathologist assisted in determining the medical cause of death (noted above).
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. – • Due to Harry's level of agitation, he did not undergo the level of observations that would and should have happened either in the emergency department or once on the Mason Unit which may have assisted in assessing his physical health. • It was clear that none of the mental health nursing staff were aware of ABD and the fact it is a medical emergency. • The decision as to whether a person has ABD is important, Dr Delaney said that" this group are vulnerable to cardiac arrest", that "deaths are multifactorial", that "normally in the background a body is maintaining safe limits for e.g. pulse rate, blood pressure, temperature, but with acute disturbance in behaviour the body loses control of these safe parameters."

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 13/8/24. 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 of the Deceased • Avon & Wiltshire Mental Health NHs trust • North Bristol NHS Trust • Avon & Somerset Constabulary

	I have also sent it to The Royal College of Psychiatrists who may find it useful or of interest. 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	 M. E. Voisin HM Senior Coroner for Avon 18/6/24