M. J. F. SHEFFIELD, O.B.E., T.D., D.L., LL.B

HER MAJESTY'S CORONER

for TEESSIDE

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CB/ Collins
18 November 2013

REGULATION 28 REPORT TO PREVENT FUTURE DEATHS

This report is being sent to:

1. The Chief Executive, James Cook University Hospital, South Tees NHS Trust

A copy of this report is being sent to:

1 [redacted]
2. The Chief Executive, Tees Esk & Wear Valley NHS Trust
3 The Chief Constable, Cleveland Police
4 The Chief Coroner

CORONER

I am CLARE BAILEY, Assistant Coroner, for the coroner area of Teesside.

CORONER'S LEGAL POWERS

I make this report under paragraph 7, Schedule 5, of the Coroners & Justice Act 2009 and regulations 28 & 29 of the Coroners (Investigations) Regulations 2013.

INVESTIGATION & INQUEST

On 25th October 2012 Mr Sheffield, the Senior Coroner, commenced an investigation into the death of STUART ARRON COLLINS, then aged 37. The investigation concluded at the end of the inquest on 15th November 2013. The conclusion of the inquest was Misadventure, the medical cause of death being Ia) hypoxic brain injury, Ib) cardiorespiratory arrest, Ic) alcohol toxicity and II) effects of diazepam & chloriazepoxide.

CIRCUMSTANCES OF DEATH

1. Mr Collins was intoxicated & fully conscious when he was taken to the A&E department at James Cook University Hospital at approximately 00.45 on 9.10.12.

2. Whilst at hospital it is likely he consumed further alcohol, most likely to be in the form of alcohol hand sanitiser gel, without the knowledge of the hospital staff.
3. He was discharged from the hospital at approx. 04.30 with a reduced level of consciousness.
4. He was taken by police to 3 Farne Walk, Guisborough.
5. Shortly after his arrival at the address he slipped into unconsciousness and suffered cardio respiratory arrest.
6. Mr Collins was transported back to James Cook University Hospital arriving at approximately 06.30.
7. He passed away at the hospital later that same day.

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. There appeared to be a degree of uncertainty as to whether Mr Collins was assessed upon his arrival at the A&E department at James Cook University Hospital ("the hospital")at approx. 00.45 or whether information previously obtained by paramedics was utilised in lieu of an assessment on arrival.
2. It was stated that Mr Collins should have had hourly nursing observations taken during his first admission to A&E on 9.10.12, ie between 00.45 and his discharge at 04.30, but none were taken.
3. Evidence was given that Mr Collins was added to the whiteboard in the A&E dept but that the information regarding the frequency of his nursing observations was not. It was stated that this led to no nursing observations being taken during his first time at A&E on 9.10.12
4. Evidence was given that the nursing notes in A&E were not fully completed and were not kept up to date. There was no apparent recording about Mr Collin's epilepsy or the need for the hand sanitiser gel to be moved out of his reach.
5. Evidence was given that the hand sanitiser gel was collected from the A&E department. However further evidence was given that the collected hand gels (estimated at 20 in number) were placed on the nurses station very close to Mr Collin's cubicle. There was contradictory evidence as to whether Mr Collins could have accessed the hand gel from the nurses station.

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.

YOUR RESPONSE

You are under a duty to respond to this report within 56 days of the date of this report, ie by 20.1.14. I can extend this period if necessary.

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 being proposed.

COPIES & PUBLICATIONS

I have sent a copy of this report to the Chief Coroner & to the other Interested Persons listed at the top of this report.

I am also under a duty to send a copy of your response to the Chief Coroner.

The Chief Coroner may wish to 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 Assistant Coroner, at the time of your response, about the release or the publication of your response by the Chief Coroner.

Clare Bailey
Assistant Coroner
Teesside Coroner Area