H M Senior Coroner for Gloucestershire
Ms Katy Skerrett

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| | **REGULATION 28 REPORT TO PREVENT FUTURE DEATHS**<br><br>**THIS REPORT IS BEING SENT TO:**<br>**1. Ms Lee, Chief Executive of Gloucestershire Hospitals NHS Foundation Trust, Trust Headquarters, Alexandra House, Cheltenham General Hospital, Sandford Road, Cheltenham, Gloucestershire GL53 7AN**<br>**2. Mr Wenman, Chief Executive of South Western Ambulance Service NHS Foundation Trust, Trust Headquarters, Abbey Court, Eagle Way, Exeter Devon EX2 7HY** |
| 1 | **CORONER**<br><br>I am Katy Skerrett, Senior Coroner for Gloucestershire. |
| 2 | **CORONER'S LEGAL POWERS**<br><br>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. |
| 3 | **INVESTIGATION and INQUEST**<br><br>On the 5th September 2016 I commenced an investigation into the death of Susan Ann Smalley. The investigation concluded at the end of the inquest on the 8th November 2017. The conclusion of the inquest was a narrative conclusion. The medical cause of death was 1A massive fronto-temporal parietal acute subdural haemorrhage with frontal contusions and occipital skull fracture. |
| 4 | **CIRCUMSTANCES OF THE DEATH**<br><br>On the 8th August 2016 at approximately 14.30 hours Susan Ann Smalley, "Susan" a 67 year old lady suffered a witnessed fall at home. She fell backwards from standing height onto hard ground. Her family rang emergency services at 14.46 hours. They made three further calls. The rapid responder arrived on scene at 15.41 hours, nearly an hour after the initial call. At this time Susan was fully conscious, had a laceration to the back of her head and was vomiting. The paramedic requested emergency back up. The ambulance arrived at 16.52 hours, just over two hours after the initial call. The delayed arrival of the ambulance was due to demand for the services being higher than the resources available. No earlier opportunity to respond to the call has subsequently been identified.<br>Susan was conveyed to the nearest A&E at Cheltenham General ("CG"). During this transfer her right pupil became dilated and her Glasgow Coma Score ("GCS") decreased to 14. Susan arrived at CG at 17.27. Soon thereafter she suffered some facial weakness. She was not formally assessed by the Emergency Department ("ED") Consultant and was not admitted to CG. Instead the Consultant decided to transfer Susan to Gloucester Royal Hospital ("GRH") on the basis that it was unclear whether Susan had suffered a stroke or a head injury. If Susan had been formally assessed at this time she would have undergone a CT examination which would have identified the significant head injury she had suffered. Instead the injury remained undiagnosed and Susan was transferred to GRH.<br>Susan arrived at GRH at 17.50 hours. Her GCS had significantly decreased at this time. Susan experienced a tonic clonic seizure. The ED Consultant administered phenytoin, vitamin K, octaplex, and requested a CT scan. The CT was reviewed at 19.45. It revealed a significant head injury. Neurosurgical opinion was sought from Southmead Hospital ("SM"). They advised urgent transfer to SM, and administration of saline and mannitol in addition to the medications that had already been administered on arrival at GRH.<br>The urgent transfer by ambulance was requested at 19.46. Two follow up calls were made. The transfer occurred at 21.11, 1 hour and 23 minutes after the initial request. The transfer was delayed due to demand for resources being higher than the resources available. However 35 |

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| | minutes of this delay could have been avoided.<br>Susan arrived at SM at approximately 22.20 hours. She was assessed, and due to the severity of her injury it was advised that she was not fit for operative intervention due to the very high likelihood of serious and permanent neurological disability. She was admitted to ICU. She was reviewed the following day and there was no change in her presentation. Following discussion with her family it was advised that active care was to be withdrawn, and palliative care commenced. Susan continued to deteriorate and she passed away on the 12th August 2016.<br>If Susan had arrived at SM earlier it is probable that she would have been fit for operative intervention. Furthermore it is probable that she would have survived surgery and had a good functional outcome. Susan's delayed arrival at SM was due to a number of factors, some of which were avoidable. |
| 5 | **CORONER'S CONCERNS**<br><br>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.<br><br>The **MATTERS OF CONCERN** are as follows. –<br>1. The sufficiency of ambulance resources that have been allocated to meet demand in the Gloucestershire area,<br>2. Whether clinicians, patients and paramedics are clear as to which hospital, either Gloucester Royal Hospital or Cheltenham General hospital, should be treating the patient.<br>3. When urgent emergency transfers are requested between hospitals, how they are appropriately expedited. |
| 6 | **ACTION SHOULD BE TAKEN**<br><br>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**<br><br>You are under a duty to respond to this report within 56 days of the date of this report, namely by 4pm 17th January 2018. I, the coroner, may extend the period.<br>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**<br><br>I have sent a copy of my report to the Chief Coroner and to the following Interested Persons<br>(1) [redacted]<br>(2) Ms Young, Chief Executive, North Bristol NHS Trust, Southmead Hospital, Southmead Road, Bristol BS10 5NB<br><br>I am also under a duty to send the Chief Coroner a copy of your response.<br><br>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 | Dated 22nd November 2017<br><br>Signature<br><br>Ms K Skerrett<br>Senior Coroner for Gloucestershire<br><br>H M Coroner |