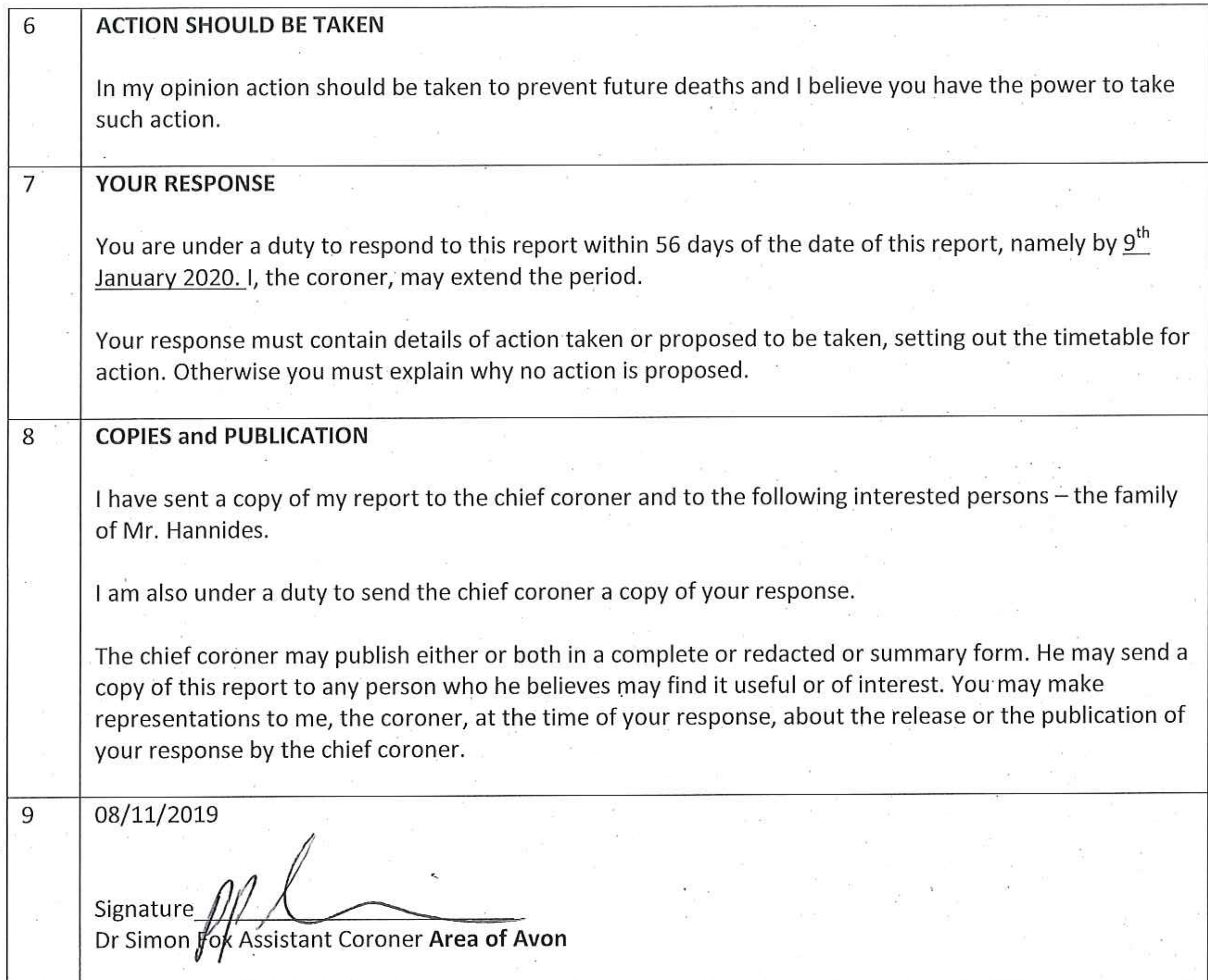
M. E. Voisin
Her Majesty's Senior Coroner
Area of Avon

11th November 2019 REF: 14517

	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO:** Simon Milner Hospital Director Spire Bristol Hospital Redland Hill Durdham Down Bristol BS6 6UT
1	**CORONER** I am Dr Simon Fox Assistant 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 10/4/2019 an investigation commenced into the death of Antonis Tofali Hannides. The investigation concluded at the end of the inquest on 8th November 2019. The conclusion of the inquest was Natural Causes.
4	**CIRCUMSTANCES OF THE DEATH** Mr. Hannides died on 29.3.19 from liver and heart disease. He underwent a hernia repair at Spire, Bristol on 21.3.19 and was discharged on 22.3.19. He reattended Spire Hospital on 27.3.19 with confusion and was assessed by a nurse and the RMO, observations were taken and urine tested. All of these should have been documented but none of them were. His consultant should have been informed immediately but he was not informed at any stage. He was sent home and admitted to the NHS on 28.3.19 and died on 29.3.19

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. – No formal system at Spire Bristol for 1) Seeing patients who reattend unexpectedly after discharge; 2) Ensuring full and comprehensive record keeping in accordance with GMC and NMC guidance; 3) Ensuring that consultants are informed immediately of any patient who reattends unexpectedly after discharge.



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 9th January 2020. 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 Mr. Hannides. 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	08/11/2019 Signature____________________ Dr Simon Fox Assistant Coroner **Area of Avon**

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