Maria Eileen Voisin

HM Senior Coroner for the Area of Avon

Annual Report

2020/2021

Paragraph 101 in the case of *R (on the application of Maughan) v Her Majesty's Senior Coroner for Oxfordshire [2020] UKSC 46* states …

"The emphasis on "investigation" and "ascertainment" of the relevant facts is consistent with leading authorities on the purpose of the inquest, which make clear that the primary purpose is to find facts, not apportion guilt. As Lord Lane CJ said in R v South London Coroner, Ex p Thompson (1982) 126 SJ 625; The Times, 9 July 1982:

> "… it should not be forgotten that an inquest is a fact finding exercise and not a method of apportioning guilt. The procedure and rules of evidence which are suitable for one are unsuitable for the other. In an inquest it should never be forgotten that there are no parties, there is no indictment, there is no prosecution, there is no defence, there is no trial, simply an attempt to establish facts. It is an inquisitorial process, a process of investigation quite unlike a criminal trial where the prosecutor accuses and the accused defends, the judge holding the balance or the ring, whichever metaphor one chooses to use."   …"

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1. ***Introduction***

My introduction to last year's report started with this short paragraph

> *"This report has been written during the most strange and unusual times in the midst of the coronavirus pandemic. Future planning is difficult, when nobody knows what the rest of 2020 will bring and indeed what lies ahead in 2021."*

I could almost write words similar to those again but as I write this report there does appear to be some light at the end of the tunnel.

This report covers the period from approximately April 2020 to March 2021. However due to the timing of when national statistics are produced the report considers those for the whole of the year for 2020 (on the activity of coroners' areas nationally and how the Area of Avon compared to that national picture). Cases which have not been concluded within 12 months are reported to the Chief Coroner each year, around the end of April, so this report will reflect on this 12 month period to April 2021.

The report will also review what progress has been made in what has been a challenging year for us all.

Finally the important role of a coroner includes making recommendations to appropriate organisations in order to prevent future deaths. This report includes details of those recommendations made during 2020.

2. ***Role of the Coroner***

A coroner is an independent judge who investigates deaths if they have reason to suspect that: the death was violent or unnatural; or the cause of death is unknown; or the deceased died while in state detention.

The pandemic has also highlighted the important role of the Senior Coroner in cross agency working, providing support and advice with planning and decision making to assist other organisations such as the local authority, and the police when managing a pandemic.

3. ***Progress with the future developments identified in previous reports?***

- The management and a desire to return to business as usual performance and recovery linked with the pandemic – this has been an ongoing struggle over the year and continues to be the case, this is considered in more detail below.
- Medical Examiner System - There are now two medical examiner systems set up and operating in the coroner area of Avon which now review a large proportion of hospital

deaths. Dr Christopher Knechtli, Consultant Haematologist and Trust Lead Medical Examiner for the Royal United Hospitals Bath NHS Foundation Trust. Dr David Crossley, Consultant in Anaesthesia and Intensive Care Medicine and Lead Medical Examiner for North Bristol NHS Trust and University Hospitals Bristol and Weston NHS Foundation Trust. Close links are developing with both Lead Medical Examiners and their teams. It is hoped that the medical examiner system of reviewing hospital deaths will result in more appropriate referrals to the coroner.

However the overall impact the medical examiner system will have on the coroner service remains to be seen. Potentially this system may lead to an increased number of referrals resulting in more post mortem examinations being necessary as well as longer and more complex inquests.

- Civica on line portal referral – this has not been implemented and it is still unclear when this will be introduced. The aim of the portal is to allow professionals to make referrals through an online link which would save time for the coroner's officers and ensure accuracy of information.

- The court audio/recording equipment – this was replaced in August 2019 which resulted in a considerable cost saving in one inquest alone prior to the pandemic. Since the pandemic it has enabled remote hearings to take place which has ensured that a lot of court hearings have continued whilst maintaining the health and safety of the staff and of those attending court.

4. ***Additional Key Achievements and Challenges in 2020/2021***

The pandemic has been the single biggest challenge to our service in 2020/2021. Whilst a death due to COVID-19 is considered to be a natural cause death the virus has had considerable impact. In an attempt to explain the impact I will separate this section into the various areas:

Staff

- Throughout the year the staff group (coroner's officers and the admin team) worked at home and only worked in the office on a rota basis primarily to cover court, the phones and the management of post.

- Home working became a necessity to keep everyone safe; matters could only be progressed using the coroner's Civica case management system which worked regardless of the location of staff.

Local Planning

- The Senior Coroner attended Avon and Somerset Local Resilience Forum (ASLRF) and multi-agency pandemic planning meetings which continued to a greater or lesser extent depending on the need during the year. The focus of all of the meetings was to plan, to act and to adapt to ensure that the whole process of death management was in a position to cope with the excess deaths and changed processes brought about locally by the pandemic. During this time many organisations worked together to manage the situation as it evolved.

National Planning and Changes

- Changes were implemented in Parliament (Coronavirus Act 2020) which assisted in allowing coroner's to maintain the work whilst operating within the requirements set by Government.

- The Senior Coroner attended (remotely) regular meetings with the Chief Coroner along with a select number of Senior Coroner's from around England and Wales. Those meetings discussed what was happening in all regions, gave useful guidance which was then disseminated to the southwest Senior Coroners. Indeed in the southwest the Senior Coroner's started to meet (remotely) every week; these meetings became invaluable, are still ongoing and are likely to continue as they have been considered by all Senior Coroner's to be a benefit to the work they do.

- There was a change of Chief Coroner in 2020 with His Honour Judge Mark Lucraft QC relinquishing the post on 23rd December 2020 and the current Chief Coroner His Honour Judge Thomas Teague QC taking up the post on 24th December 2020.

- The Chief Coroner sent out guidance to assist with the way the work of a coroner could adapt but remain within the rules and ensuring the high standards rightly expected by the public were maintained. That guidance included:

    - Guidance no 34 – "Chief Coroner Guidance – Covid-19" (dated 26th March 2020). "This Guidance is designed to help coroners continue to exercise their judicial decisions independently and in accordance with the law, but in the context of the extraordinary pressures which are present."

    - Guidance no. 35 – "Hearings during the Pandemic", (27th March 2020). This guidance as it says provided essential assistance with court hearings, it confirmed that only hearings that should be taking place in a coroner's court during the pandemic emergency are those which are urgent and essential business.

    - Guidance no 36 – "Summary of the Coronavirus Act 2020 provisions relevant to coroners" (dated 30th March 2020). This covered the essentials within the legislation affecting coroner's such as the medical certificates of the cause of death (MCCDs) and cremation changes.

- Guidance no. 37 – "Covid-19 Deaths and Possible Exposure in the Workplace" (dated 28th April 2020, Amended 1st July 2020). This was issued due to the provisions that a death may also sometimes be notifiable to the Health and Safety Executive ('HSE') under the Reporting of Injuries, Diseases and Dangerous Occurrences Regulations 2013 ('RIDDOR'). "Regulation 6(2) of RIDDOR requires a report to be made where "any person dies as a result of occupational exposure to a biological agent". The expression "biological agent" includes the virus which causes the COVID-19 disease. Consistent with the requirements of RIDDOR, the HSE has published guidance that death as a result of work-related exposure to the virus must be subject to the reporting procedure."

- Guidance no. 38 – "Remote Participation in Coronial Proceedings via Video and Audio Broadcast" (dated 11 June 2020). As more and more hearings were dealt with by a video link this provided information about conducting hearings with participants accessing the hearing remotely whilst the coroner was physically present in court. This was necessary as there are very strict rules around the recording and broadcasting of an inquest hearing.

- Guidance no.39 – "Recovery from the Covid-19 Pandemic" (dated 29th June 2020 and revised 21st May 2021). As is stated within that guidance … "The Covid-19 pandemic has had a significant impact on the coronial system. As restrictions ease in England and Wales, it is vital that we take decisive steps to deal with any outstanding cases and help the system to recover as quickly as possible. The purpose of this note is to assist all coroners to develop a robust, dynamic recovery plan that will deal with the challenges the service is currently facing. It should also be noted, however, that by necessitating changes in our ways of working, recovery planning provides us with an opportunity to make improvements that will be beneficial in the longer term.

  The key pillars of recovery for our service are:

  a. Arranging appropriate COVID-secure facilities for the conduct of inquests, including those inquests that are complex;
  b. Ensuring each coroner Area has the number of coroners it needs;
  c. Maximising the use of assistant coroners to tackle any backlog of cases;
  d. Ensuring each coroner Area has appropriate levels of support staff; and
  e. Increasing coroners' capacity to undertake inquests with remote participants, including through the provision of better IT equipment and training where required. "

The guidance listed above demonstrates how the coronial system was placed under immense pressure during the last year to ensure that the work of the coroner was maintained.

Inquests

- The Chief Coroner said in his annual report (referred to in more detail in section 5 below) "that many inquests have had to be adjourned or postponed … some courtrooms will not be suitable for holding anything but the most straightforward of inquest hearings … many jury inquests have had to be postponed. Sufficient resource will need to be provided by local authorities to coroners to enable then to carry out this part of their statutory functions …"

- Some court hearings needed to be cancelled which unfortunately meant that some families were disappointed and those cases could not be concluded. Some cases could not be listed as it was not safe for people to come to court.

- Avon lost 56 days of planned court – that meant that staff had to cancel and then re-schedule each of those hearings, which caused considerable additional work.

- Initially court hearings which necessitated attendance of witnesses and interested persons came to a halt. Hearings did take place where they involved the coroner sitting alone. A letter was sent to all stakeholders which explained the position:

> "As you will be aware, the situation regarding COVID-19 is changing rapidly … there are already requirements for social distancing… many people are self-isolating … there are increased pressures on the emergency services; healthcare and those that work with the elderly. Therefore after much deliberation I have made the difficult decision to adjourn all Inquest hearings that require witnesses to attend, from 4pm on Friday 27th March 2020 until the 1st September 2020. All interested persons, witnesses and families will be contacted…For everyone it is acknowledged that lack of certainty is unhelpful and at this time it was felt a clear decision, however difficult is the right way to proceed... This will ultimately result in a backlog of cases going forward but the balance that needs to be struck at this time is keeping people safe and healthy; maintaining the core business function of the service and working with our stakeholders to provide some certainty and assistance with their core business."

- Jury inquests were not capable of being listed or heard due to the fact there was no suitable venue to accommodate the need for social distancing. (A jury in a coroner's court consists of 7-11 members.) The last jury inquest was heard at Flax Bourton Coroner's Court in March 2020 and the next jury inquest could not take place until a suitable venue could be found. A significant consideration when assessing the various venues was also the cost. That work was undertaken and eventually Ashton Court was approved, a facility which could accommodate a socially distanced jury and interested persons at a cost which was acceptable.

- However it became clear that there would be a backlog of cases created by a number of factors due to the pandemic, some due to the inability to list them in a suitable covid-safe venue but also due to the delay created by other organisations who were also affected by the pandemic e.g. the hospitals, care homes, the health and safety executive and the police.

- In February 2021 interviews were held for the post of assistant coroner, there were 2 successful candidates who were both appointed. This makes a team of 7 coroners – the Senior Coroner, the area coroner (who is a 0.8 full time post) and 5 assistant coroners who sit on an ad hoc basis.

Court

- Risk assessments, reconfiguring the court layout, screens, masks, hand sanitising stations and signage all had to be worked on and put in place at the court and office buildings which took some time to achieve.

- In relation to court hearings the Coroner's Court Support Service, the team of volunteers who offer support to bereaved families and other witnesses when attending court were suspended during the pandemic due to the risk to the volunteer's health and also due to the numbers who were then allowed to safely attend the court.

- Remote (Zoom, Skype and Teams) became the preferred option over face to face meetings and continues to be the case now. Teams was integrated with the court recording system.

- At Flax Bourton there are 2 courts the main court – court 1 and court 2 which is much smaller. Due to the size court 2 was only used for small hearings due to the rules on social distancing. Court 1 has been the main court in use with significantly reduced numbers attending.

5. Coroner Statistics 2020

The statistics for Avon for the years 2006 – 2020 as compared against the national picture appear in Annex A.

It should be noted that comparing coroner areas is fraught with difficulties as I have highlighted in previous reports.

Coroner's statistics are produced by the Ministry of Justice (MOJ) annually together with the Office for National Statistics (ONS), and for 2020 they were produced on 13th May 2021. The latest version is available to review for the whole of England and Wales by following this link:

https://www.gov.uk/government/collections/coroners-and-burials-statistics

One of the main points the report makes is that the statistics this year cover the Covid-19 pandemic. During this period the government passed the Coronavirus Act 2020 which introduced temporary easements to death management and affected the way deaths have been reported to coroners. Caution should therefore be used when making comparisons to previous years.

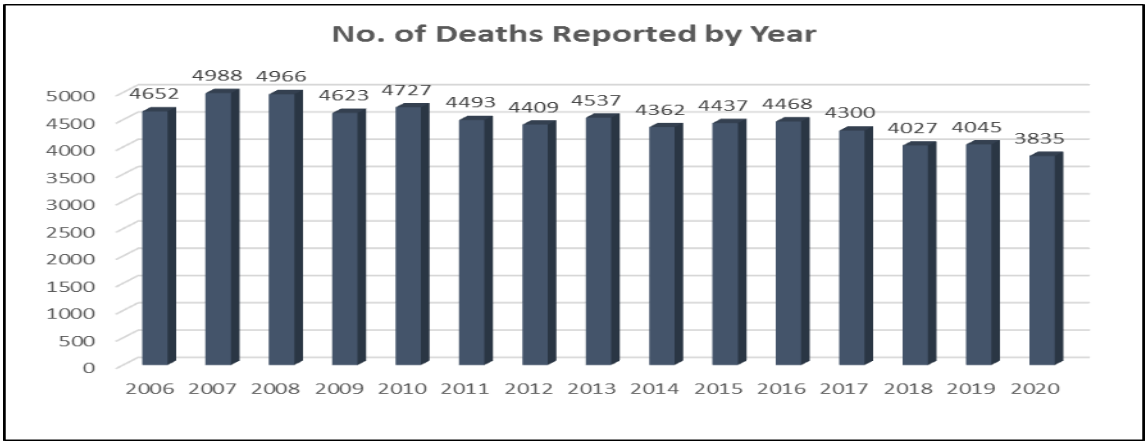
In last year's report I was not able to comment on the Chief Coroner's annual report because at the time of writing his report has not been published. This year The Chief Coroner has published a report which essentially covers 2 years 2018 – 2020 and can be found by following this link:

https://www.gov.uk/government/publications/chief-coroners-combined-annual-report-2018-to-2019-and-2019-to-2020

The Chief Coroner confirms that there are now 85 Coroner areas and that the long term joint target with the Ministry of Justice is to reduce the number to around 75. The purpose of reducing the number of coroner areas include: greater consistency and uniformity of approach within the coroner service as well as local authorities concerned.

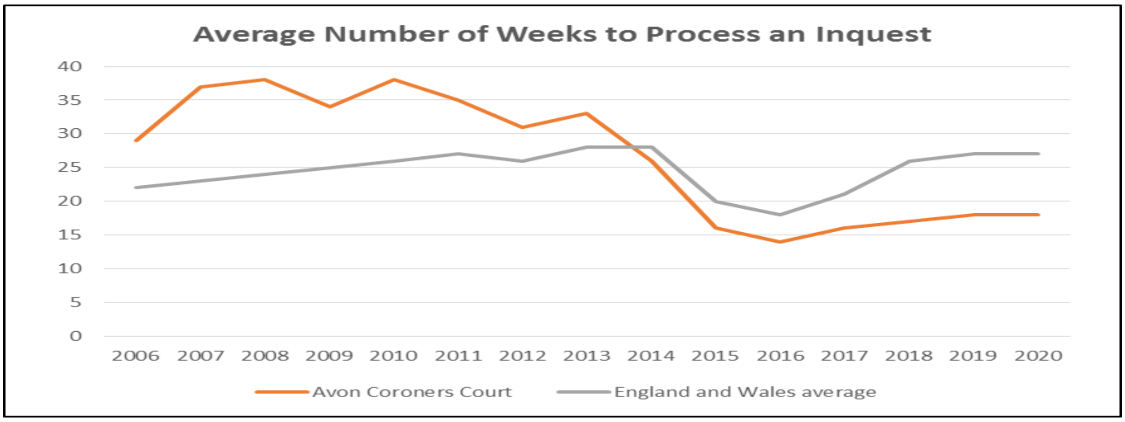
Based upon the numbers of deaths reported Avon was the 8th largest area in 2020 with 3,835 (deaths reported), the largest being Hampshire, Portsmouth and Southampton with 6,880 (deaths reported). **Figure 1** shows the numbers of deaths reported to Avon from 2006 to 2020.

Figure 1



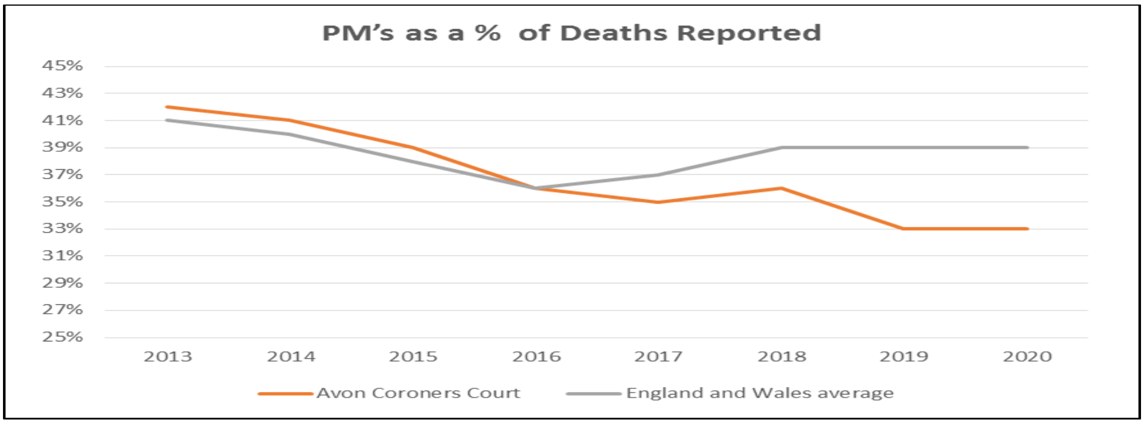
In 2019 the average time to process an inquest (from the time the death was reported to the inquest being concluded) in Avon was 18 weeks, compared to the average of 27 weeks for England and Wales over the same period. In 2020 this figure has remained the same; 9 weeks less than the average for England and Wales as shown in **Figure 2**.

Figure 2



Post mortem examinations as a percentage of the number of deaths reported in 2019 in Avon was 33% with the average (mean) for England and Wales being 39%. In 2020 these figures remained unchanged; this is shown in **Figure 3**

Figure 3

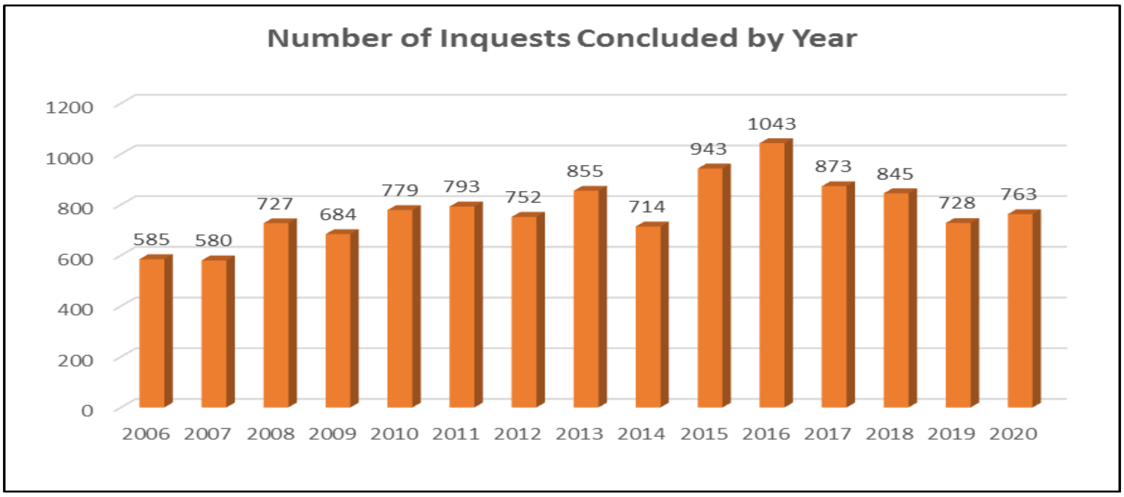


- In 2018 the number of inquests held in Avon was 845 (see **Figure 4**), of which 9 were jury inquests, those jury inquests taking up 16.2 weeks of court time.

- In 2019 there were 728 inquests held in Avon of which 7 were jury inquests, those jury inquests taking up 9 weeks of court time. In addition in 2019 there were 8 inquests that lasted 5 days or more.

- In 2020 there were 763 inquests held in Avon of which there were 3 jury inquests, those jury inquests taking up 5 weeks of court time. In addition there were 5 inquests that lasted 5 days or more. There were also a number of inquests which lasted more than 1 day. A significant achievement taking into account the difficulties brought about by the pandemic.

Figure 4



It is a requirement that senior coroner's complete a notification each year around the end of April detailing those cases which have not been concluded within 12 months, that report is provided to the Chief Coroner. A summary of the report can be seen at **Figure 5** below.

There are often good reasons why a case is outstanding for over 12 months. Some of those cases involve enquiries by other bodies which results in the coroner's investigation being delayed, for example: an ongoing police enquiry; a criminal case or prosecution; a death abroad; Health and Safety Executive or Prison and Probation Ombudsman inquiries; inquiries by the Independent Office for Police Conduct (IOPC); investigations by the accident investigation bodies such as the Air Accidents Investigation Branch or even a Root Cause Analysis or similar by a Trust. The coroner's investigation is therefore usually and appropriately put on hold pending the outcome of another organisations investigation.

In the 2021 report Senior Coroner's were asked to include cases which were delayed due to Covid-19. The effect of the pandemic on cases over 12 months old can clearly be seen.

Figure 5

Reason for delay	**2016**	**2017**	**2018**	**2019**	**2020**	**2021**
Death abroad	1	3	3	2	1	3
Investigation/Prosecution by external authority	9	3	6	5	14	10
Complex case	2	2	2	5	8	1
Prepared for inquest			1	3	6	
Current criminal proceedings in the Crown Court				6	3	18
Covid-19						29
Total cases over 12 months old	**12**	**8**	**12**	**21**	**32**	**61**

6. ***Prevention of Future Deaths***

The avoidance of future deaths has long been recognised as a major purpose of an inquest, essentially improving public health and safety. Where, during the course of an investigation, there are matters which give rise to a concern that a risk of further deaths exists; action should be taken by the coroner. To prevent the reoccurrence of, or to eliminate or reduce the risk of death, the coroner must make a report to the person who may have the power to take action.

The recipient of the report must respond to the coroner within 56 days setting out the proposed action to be taken and a timetable for completing it, or explaining why they do not propose to take action. The coroner may send a copy of the report and the response to any person who the coroner believes may find it useful or of interest.

The coroner also provides a copy of the report and response to the Chief Coroner and those reports are published by him.

The prevention of future deaths reports which were written in 2020 are detailed in Annex B. There were 2 reports written in 2020 following the inquests of: Julie O'Connor and Julie Brass.

7. ***Future Developments:***

Last year was dominated by the coronavirus pandemic and this continues to dominate the service; the plans at this time therefore include:

- To manage the backlog of cases whilst maintaining standards.
- The desire to return to business as usual performance.

To achieve this there needs to be sufficient staffing to carry out the work and a venue for jury or larger inquests. That said much will also depend on whether there are any further Government restrictions placed on all of us and the service.

8. ***Acknowledgements***

The senior coroner would like to thank the team for their continued commitment during the most difficult of times during the past year.

Thank you.

Maria Eileen Voisin

HM Senior Coroner

Annex A: Statistics from 2006 – 2020

Year	No. of deaths reported in Avon	Avg time to process an inquest in Avon (weeks)	England and Wales - avg time to process an inquest (weeks)	No. of inquests opened in Avon	No. of inquests concluded in Avon	Inquest as a % of deaths reported in Avon	England and Wales - inquest as a % of deaths reported	No. of PM's in Avon	PM's as a % of deaths reported in Avon	England and Wales - PM's as a % of deaths reported
2020	3835	18	27	643	763	17%	16%	1276	33%	39%
2019	4045	18	27	644	728	16%	14%	1345	33%	39%
2018	4027	17	26	813	845	20%	13%	1458	36%	39%
2017	4300	16	21	750	873	17%	14%	1510	35%	37%
2016	4468	14	18	1037	1043	20%	16%	1597	36%	36%
2015	4437	16	20	934	943	19%	14%	1708	39%	38%
2014	4362	26	28	707	714	13%	12%	1800	41%	40%
2013	4537	33	28	847	855	15%	13%	1927	42%	41%
2012	4409	31	26	779	752	18%		1812	41%	
2011	4493	35	27	828	793	16%		1842	41%	
2010	4727	38	26	808	779	17%		2103	44%	
2009	4623	34	25	719	684	15%		2257	49%	
2008	4966	38	24	732	727	14%		2388	48%	
2007	4988	37	23	592	580	13%		2424	49%	
2006	4652	29	22	598	585	15%		2439	52%	

Annex B: Reports to Prevent Future Death 2020 (redacted copies)

There were 2 reports written in 2020 following the inquests of: Julie O’Connor and Lesley Julie Brass. Extracts from those reports appear below.

1. Deceased name: Julie O’Connor

Date of report: 30th January 2020
Report sent to: Secretary of State for Health and Royal College of Obstetricians and Gynaecologists
Report by: Maria Voisin

INVESTIGATION and INQUEST
On 17/04/2019 I commenced an investigation into the death of Julie Sandra O'Connor. The investigation concluded at the end of the inquest 30th January 2020. The conclusion of the inquest was natural causes contributed to by neglect.
Her medical cause of death was recorded as: 1a) metastatic squamous cell carcinoma of the cervix

CIRCUMSTANCES OF THE DEATH
The brief circumstances were … Julie O’Connor had a smear test in September 2014 which was reported as normal when it was not; she was examined by gynaecologists who did not diagnose her condition in August and November 2016. It was not until she was seen in March 2017 that she was appropriately diagnosed and treated for cervical cancer. Unfortunately despite treatment at that time her condition deteriorated, she developed metastatic disease due to the delayed diagnosis and she died on 4th February 2019 at St Peter's Hospice from metastatic squamous cell carcinoma of the cervix.

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. –
In this case as well as the fact that the smear test was incorrectly reported there were also 2 occasions when there was a failure to recognise a clinically obvious cancer of the cervix or a failure to recognise a need for further assessment in August and November 2016. In addition the evidence of the experts was that the abnormal appearance of the cervix should also have been diagnosed in February 2017.
The North Bristol NHS Trust have developed a guide for “the management of abnormal cervix, ectropian, and post coital bleeding”* and it is the view of the trust that if this guide had been in place at the time that Julie’s medical condition would have been picked up earlier.

2. Deceased name: Lesley Julie Brass

Date of report: 27th May 2020
Report sent to: Chief Executive North Bristol NHS Trust and Head of Clinical Governance North Bristol NHS Trust
Report by: Robert Sowersby

<u>INVESTIGATION and INQUEST</u>
On 30th October 2018 an investigation commenced into the death of Lesley Julie BRASS, aged 58. The investigation concluded at the end of the inquest on 2nd March 2020.
The medical cause of death was:
1a) Cardiac arrhythmia
1b) Hyperkalaemia (untreated)
1c) Infected scalp laceration (treated), diabetes mellitus, pneumonia
2) Ischaemic heart disease
The narrative conclusion of the inquest was: Mrs Brass was an inpatient on the Plastic Surgery ward at Southmead Hospital when she developed severe hyperkalaemia, a condition requiring emergency treatment. The Hospital's own internal procedures required that severe hyperkalaemia must be treated within 30 minutes, and the relevant staff looking after her were aware that she faced a life threatening emergency, but the window for effective treatment expired without the required treatment being given, and as a result Mrs Brass went into cardiac arrest and sadly died. Her death was contributed to by neglect.

<u>CIRCUMSTANCES OF THE DEATH</u>
As above, the circumstances of the death were that:
- Mrs BRASS had a number of co-morbidities, including diabetes, high cholesterol, high blood pressure, and severe peripheral neuropathy
- She fell at home on 13 October 2018, sustaining a head injury
- Her head wound subsequently became infected, and she was admitted to Southmead Hospital by ambulance on 19 October 2018
- On 20 October 2018 she was transferred to Gate 33A (the Plastic Surgery ward)
- While she was an inpatient on the Plastics ward Mrs BRASS's kidneys were under additional strain (as a result of her wound infection) and she began to experience hyperkalaemia (high potassium levels in her blood)
- A blood sample was taken from Mrs BRASS at 10.30am on 22 October 2018, and subsequently analysed at the hospital laboratory
- When the sample was analysed Mrs BRASS's potassium level was 7.1, a reading which indicates "severe hyperkalaemia"
- Severe hyperkalaemia is a medical emergency, and should be treated within 30 minutes of the condition being recognised
- Untreated, it carries a very high risk of cardiac problems which can be fatal
- The Trust which runs Southmead Hospital, recognising the risk posed by hyperkalaemia, has produced a Standard Operating Procedure ("SOP") to indicate how the condition should be dealt with

- That SOP states that severe hyperkalaemia (defined as a potassium level of 6.5 or above) is “potentially life threatening” and “needs emergency treatment”
- The SOP mandates that a patient with severe hyperkalaemia must be given intravenous calcium (either 10ml of 10% Calcium Chloride or 30ml of 10% Calcium Gluconate) within 15-30 minutes of the condition being recognised
- Shortly before 12.30pm on 22 October 2018 the laboratory phoned Mrs BRASS’s potassium reading (of 7.1) through to the Plastics ward
- The call was taken by a member of the Hospital’s nursing staff, who discussed the alarmingly high potassium result with a number of other members of nursing staff on the ward
- Once the Plastics ward had been notified of that potassium result, the team who were looking after Mrs BRASS had a clear duty (under the Trust’s own SOP) to ensure that she received IV calcium within 30 minutes
- In order for that treatment to be administered, Mrs BRASS first had to be seen by a doctor: three members of the nursing staff gave evidence to the effect that they knew that Mrs BRASS was experiencing a life threatening medical emergency (therefore they must have understood the importance of making sure she was seen by a doctor)
- The nursing staff made various attempts to get a doctor to come and see Mrs BRASS, but these were completely ineffective
- Not only did Mrs BRASS not receive the IV calcium that she required within 15-30 minutes (as required by the Trust’s own SOP), but she was not even seen by a doctor in that time
- She was subsequently taken off-ward for an ultrasound scan: Mrs BRASS was booked into the radiology ward at 1.13pm, and went into a fatal cardiac arrest at 1.22pm on 22 October 2018
- By the time that Mrs BRASS went into cardiac arrest almost an hour had passed since the Plastics ward had been notified of her severe hyperkalaemia, and she still had not been seen by a doctor, much less received the required medication
- There was clear (uncontested) evidence that if she had been treated in line with the Trust’s SOP she would probably have survived
- There was no doubt whatsoever in my mind that Mrs BRASS’s death was contributed to by neglect.

<u>CORONER’S CONCERNS</u>

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. –

During the course of the pre-inquest investigation, and at the inquest itself, evidence came to light which led me to conclude that the Trust in general, and the Plastic Surgery

department in particular, was/were reluctant to investigate Mrs Brass's death properly, and to be open about their findings.
I am particularly concerned that a number of the consultants from the Plastic Surgery department failed to co-operate with and/or progress the investigation.

In summary:

- [redacted] opened an initial DATIX incident report in respect of Mrs BRASS's death on 26.10.18 (only 4 days after she died): that form correctly identified the possibility that the staff at Gate 33A had not reacted appropriately in response to her high potassium reading (ie, that they had not complied with the Trust's SOP on hyperkalaemia)
- The DATIX form erroneously described the level of harm caused as "Low (minimal harm caused)" – the effect of this misdescription was that the resulting investigation was subject to a lower level of scrutiny/oversight than it would have attracted if it had been categorised correctly
- [redacted] was, sadly, unavailable to give evidence in person at the inquest, so I do not have any explanation for this error other than that contained in her statement (dated 24.02.20) which is: "I entered the level of harm as low until the actual level of harm was ascertained".
- In her written statement [redacted] confirmed that [redacted] and I agreed that due to the raised serum potassium at the time of her death an internal review should be carried out". To reiterate: by 26.10.18 at the latest the Trust knew, or had reason to suspect, that Mrs BRASS's raised potassium level (and the ward's response to it) might be of significance in relation to her death
- [redacted] then emailed three of the Consultants in the Plastics department – [redacted] indicating, amongst other things "I feel we should review her care as this is an unexpected death"
- In her written statement [redacted] indicated "my expectation at this time [ie, after completing the initial DATIX form / sending those emails] was that the care received by Lesley BRASS would be reviewed through the Mortality review process using the Structured Judgment Review (SJR). If during this review process there was an outcome of 'poor' or 'very poor' care then there would be a more detailed review and discussion of the case within the Plastic Surgery Mortality and Morbidity meeting"
- Disappointingly there was no such review, and neither does there appear to have been any substantive response to her email from any of the three Plastics consultants named above [redacted]
- [redacted] statement goes on to indicate: "I understand that a request for a Mortality review was sent to a Plastic Surgery Consultant, but it was not completed"
- I was unable to ascertain who this unnamed consultant might be (and whether it was one of those who had already been contacted). [redacted] was the only consultant from the department who gave evidence at the inquest: to my surprise he indicated that he might have been the person who had been asked to carry out the mortality review, or he might not be, but he could not say either way

- [redacted] conceded in evidence that whether he was the consultant in question or not, no such review was carried out

- The internal investigation therefore stalled completely: the same department that might potentially be the subject of criticism in respect of this unexpected death had been invited to investigate itself, and had simply not done so – further, there was no extra-departmental oversight which might have picked up on this, because the DATIX had been miscategorised
- The need for some form of internal investigation – given that a patient had died unexpectedly – only seems to have been recognised again some 5-6 months later, in March/April 2019, when the our (ie, the coroner's) office requested further evidence from the hospital in respect of Mrs BRASS's death
- [redacted] indicates in her written statements that at that stage she requested a copy of the Mortality review, but was told that there wasn't one. She then contacted [redacted] again "and requested a review of the medical records"
- [redacted] statement goes on to record that "between May and July 2019, I had numerous conversations with the legal team… regarding the investigation of the incident form. We all had concerns that this was a possible serious incident because the raised serum potassium had not been treated within the time frame of the NBT Hyperkalaemia policy. I also had numerous conversations with [redacted] regarding the treatment of hyperkalaemia" (underlining added)
- However, even though the clinical governance and legal teams both had concerns about Mrs BRASS's treatment, and believed that further investigation was required, the DATIX form indicates that [redacted] had been asked to provide a medical report for the Coroner and… the Plastic Surgery specialty felt that the report written by [redacted] for coroners (sic) was a sufficient investigation" (see DATIX form)
- I was later provided with a statement from [redacted] (dated 05.11.19) as part of my investigation into the events surrounding Mrs BRASS's death (well before I became aware of the significance that the Plastics team were attaching to his evidence): it is important to note that the contents of that statement in no way represented an adequate assessment of, or investigation into, the cause of Mrs BRASS's death – a viewpoint that [redacted] openly agreed with when he later gave live evidence at the inquest
- When I initially reviewed [redacted] statement (well before the inquest) I was in fact struck by the surprising absence of relevant information within it. Although he did make reference to the high potassium reading that was phoned through to the ward by the laboratory:

(i) He did not give any indication at all of the clinical significance of that reading (ie, he did not mention within his statement that it represented a potentially life-threatening medical emergency, or that it carried with it a risk of cardiac arrest)
(ii) He did not make any reference to the fact that the hospital/Trust had a SOP governing how its staff (and therefore the Plastics department) should respond to such a reading

(iii) He set out what the ward staff did (eg, they tried to contact the Plastic Surgery SHO, and performed an ECG), but he did not indicate that there was anything that they should have done but did not, or give any indication that their response to the telephone call was inadequate (as it manifestly was)
(iv) He did not indicate anywhere within his statement that Mrs BRASS should have been seen by a doctor, and given appropriate medication to counteract her severe hyperkalaemia, within 30 minutes
(v) He did not say anything at all in his statement which would give the reader the impression that the staff on the Plastic Surgery ward had done anything wrong, or that the treatment Mrs BRASS received was inadequate
(vi) He described the fact that Mrs BRASS subsequently went into cardiac arrest, but he did not indicate within his statement that there was any connection between her untreated hyperkalaemia and that cardiac arrest

- I was in fact so surprised by the absence of salient information in [redacted] statement that I took the unprecedented step of inviting him to write to me explaining why his statement made no mention of the fact that Mrs Brass's potassium reading represented (according to the Trust's own SOP) a "severe, potentially life threatening" condition which required (but did not lead to) "emergency treatment". I later subsequently received a response from the Trust's solicitors, but none from [redacted]
- The absence of fundamentally important information from [redacted] statement was striking enough in any event, but it is even more striking in light of the knowledge (later acquired) that the Plastic Surgery team apparently regarded his statement as a sufficient investigation of Mrs BRASS's unexpected death. It is possible of course that there was an earlier, more comprehensive version of [redacted] statement, which did look at these issues: but if that was the case, then (i) it would be hard to understand why I was sent such an emasculated version of the statement, with most of the important evidence removed, and (ii) I imagine that [redacted] would have mentioned the existence of an earlier statement when I put it to him that the statement I had from him was in no way a sufficient investigation of Mrs BRASS's death
- Returning to the chronology of the Trust's internal investigation: on 10.06.19 the legal team chased [redacted] and one of her colleagues [redacted] for an update on the incident review after receiving a complaint from Mr BRASS. The legal team (quite rightly) emphasised "the importance of establishing whether if by treating the potassium urgently… there might have been a different outcome"
- [redacted] then (according to [redacted] written evidence) "acknowledged that he is not an expert in high potassium… [and] stated that if the Coroner wishes an expert medical opinion then we would need a statement from the medical/renal team in this case". That is of course perfectly correct and proper
- However, the next step – bizarrely in light of this conclusion – was not to ask someone from the Renal team for such an opinion, it was to close the incident report on 02.07.19 in accordance with [redacted] opinion that "this patient was significantly unwell with unresponsive high potassium. The mortality predicted was very high… In retrospect it would have been best not to transfer the patient to USS [the ultrasound

scanning suite] under these circumstances. Whilst the cardiac events would not have been avoidable it may be that the environment for resuscitation was more appropriate on the ward" (see [redacted] statement, and pg.3 of the updated DATIX form – underlining added).

- It is remarkable to me that [redacted] would acknowledge that he is not the appropriate person to offer an opinion on whether there might have been a different outcome with appropriate treatment, and then go on to offer an opinion on that very issue
- It is also surprising and disappointing that [redacted] (part of the clinical governance team), knowing that [redacted] was by his own admission not the appropriate person to given an opinion regarding the causative significance of Mrs BRASS's lack of treatment, would then close the DATIX incident report off the back of that same opinion
- The Trust then had to re-open the recently closed DATIX incident only weeks later (on 19.07.19) after discussion with [redacted] of the Trust's legal team prompted [redacted] to obtain an independent (in-house) Renal opinion, which confirmed, unsurprisingly, that Mrs BRASS's potassium level should have been dealt with more promptly as per the SOP, and that her death should be investigated under the Serious Incident Review process. These were, with respect, facts that were self-evident within days of Mrs BRASS's death
- I note that when the Trust did belatedly obtain the input of an appropriate specialist in relation to the question of causation, his opinion was entirely different to [redacted]

"Effective treatments which can be given quickly such as Calcium Gluconate injection, nebulised Salbutamol and IV Insulin & Dextrose infusion can help to rapidly protect the heart from the effects of as well as reduce high potassium levels. If Mrs Brass had been treated with such measure within 30 minutes, I consider it is probable the cardiac arrhythmia would have been avoided" (Statement of [redacted], Consultant Renal Physician, dated 18.12.19, underlining added)

- The Root Cause Analysis report which was subsequently conducted into Mrs BRASS's death (final version produced 30.10.19) concluded that the root cause of her death was that "the recognition, escalation and treatment of acute life threatening hyperkalaemia (high potassium level in blood) at the point of it measuring 7.1 mmols did not follow the Trust guidelines"
- Given what had happened on the Plastic Surgery ward on 22.10.18 (or rather what hadn't happened), this conclusion was inescapable: Mrs BRASS had required emergency treatment from a doctor within 30 minutes, but almost an hour later she hadn't even been seen by a doctor, and certainly hadn't had the life saving drugs she required
- It has been obvious to all concerned in this case – before, during, and after the inquest – that the Trust's SOP on hyperkalaemia was not followed by the staff on the Plastics ward

• Notwithstanding that, on 12.10.19 the Plastic Surgery team’s head of clinical governance [redacted] had sent various recipients, including [redacted] who was involved in preparing the RCA report), an email which contained the following:

“My reading of this unfortunate incident is that, although the plastic surgery juniors were hard to contact, the hyperkalaemia guidelines were responded to pretty much as per the guidelines. This patient was refractory to initial treatment [here he is referring to an earlier episode of hyperkalaemia, which was treated] in the period leading up to her death, and as such, in hindsight, her escalating hyperkalaemia and death was possible (please correct me if I’m wrong) inevitable, or at least very hard to avoid…”

• Given that every relevant piece of evidence I have seen/heard in this case indicates that the guidelines were not followed: I am confused and concerned as to how or why the head of clinical governance for the Plastics team could conclude otherwise
• For completeness, I should note that almost the entire investigation (above) was carried out in the midst of a Trust-wide clinical governance improvement drive.

As is, I hope, clear from the outline that I have presented above, this case has left me worried about the investigation of serious untoward incidents generally, and extremely concerned at the attitude and behaviour of the Plastic Surgery department.

The evidence as a whole demonstrates to me a department that has – at Consultant level – been serially unwilling to acknowledge, respond to, investigate, be open about, or admit to its mistakes. The attitude and approach of the Plastic Surgery department, facilitated in part by failings in the approach of others involved in the initial DATIX investigation, creates a risk of further deaths in the future unless action is taken: a department which refuses to investigate or accept its mistakes cannot learn from them.

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.