Maria Eileen Voisin

HM Senior Coroner for the Area of Avon

Annual Report

2021/2022

Paragraphs 30-32 in the case of R (Wandsworth) v HM Senior Coroner for Inner West London [2021] EWHC 801 (Admin) it states …

"30. The level of certainty, or "degree of conclusivity" (per Lady Arden) required of factual findings or conclusions in a coroner's inquest is the same as the standard of proof in civil adversarial proceedings, namely the balance of probabilities: R (Maughan) v HM Senior Coroner for Oxfordshire [2020] UKSC 46.
31. In jury inquests, the coroner must determine which conclusions or findings to leave to the jury by reference to what has become known as the 'Galbraith plus' test: R v Galbraith [1981] 1 W.L.R. 1039; R (Secretary of State for Justice) v HM Deputy Coroner for the Eastern District of West Yorkshire [2012] EWHC 1634 (Admin). That test has two components:
(i) whether there is evidence upon which the jury properly directed can properly reach the particular conclusion or finding; and
(ii) whether it would be safe for the jury to reach the conclusion or finding.
In many cases, where there is evidence upon which a jury properly directed could properly reach a particular conclusion or finding, then it is likely to follow that the jury could reach it safely: R (Chidlow) v HM Senior Coroner for Blackpool and Fylde [2019] EWHC 581 (Admin). Where, as in the present case, there is no jury, the coroner will naturally consider the safety of any conclusion or finding he or she proposes to make as well as the sufficiency of the evidence available to support it, but need not expressly articulate a self-direction on both limbs of the 'Galbraith plus' test.
32. For causation of death to be established, the threshold to be reached is that the event or conduct said to have caused the death must have more than minimally, negligibly or trivially contributed to it. That question is to be determined on the balance of probabilities. Combining the threshold for causation and the standard to which it must be established, "the question is whether, on the balance of probabilities, the conduct in question more than minimally, negligibly or trivially contributed to death": R (Tainton) v HM Senior Coroner for Preston and West Lancashire [2016] EWHC 1396 (Admin), at §41. "

Contents

1. ***Introduction***

This report covers the period from approximately April 2021 to March 2022. However due to the timing of when national statistics are produced the report considers those for the whole of the year for 2021 with regard to the activity of coroners' areas nationally and how the Area of Avon compares 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 2022.

The report also reviews 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 2021.

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

The role of the Coroner is succinctly summarised on the website set up for the *Fishmongers Hall Inquests* which states in relation to inquests …

> "An inquest is a fact-finding exercise, conducted where an individual has died in certain circumstances. The purpose of an inquest, conducted by a coroner with or without a jury, is to establish reliable answers to four important but limited factual questions as set out in section 5 of the Coroners and Justice Act 2009, namely:
>
> 1. the identity of the deceased;
> 2. the place of his/her death;
> 3. the date and time of death; and
> 4. how he/she came by their death.
>
> The inquest is a form of public investigation to determine the truth. It is not a trial so there are no formal parties, just interested persons. It is an inquisitorial process to establish facts. The process of investigation is unlike a trial where the prosecutor accuses and the accused defends.
>
> An inquest is not a method of apportioning guilt or blame, as would be the case with a criminal trial. An inquest conclusion cannot be framed in such a way as to appear to determine matters of criminal liability on the part of a named person or civil liability. There are no parties, no indictment, no prosecution, no defence, and no trial; there is simply an attempt to establish the facts.

> The inquest is conducted by a coroner. In certain inquests a coroner may sit with a jury. The coroner (whether sitting with or without a jury) hears evidence relating to the circumstances of the death of a deceased person."

In relation to the Coroner specifically it says …

> "A coroner is an independent judicial office holder acting on behalf of the Crown to investigate the cause and circumstances of violent or unnatural deaths, or sudden deaths of unknown cause.
>
> Coroners are appointed by and paid via the local authority for their district, but they are not local authority employees and are independent of both local and central government."

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

Last year the future developments were again dominated by the coronavirus pandemic and the plans at that time, *subject to having sufficient staffing and a venue for jury or larger inquests to be heard*, were:

- *To manage the backlog of cases whilst maintaining standards*. This is constantly being worked on and the older cases are being targeted to ensure that they are prioritised, the progress of this is slower than anticipated because of the staffing issues (see below).
- *The desire to return to business as usual performance*. Owing to there being insufficient staff to carry out the work and difficulties in recruitment this has not been achieved but continues to be the aim.

The venue for jury or larger inquests was achieved and currently Ashton Court is used for these hearings.

4. ***Additional Key Achievements and Challenges in 2021/2022***

- I was appointed by HHJ Thomas Teague QC, the Chief Coroner on 7 September 2021 to be one of five Senior Coroner's to act as a Regional Leadership Coroner.
- I was invited to join the cadre of DVI (Disaster Victim Identification) Coroners by HHJ Thomas Teague QC, Chief Coroner on 23 September 2021, which I accepted. The cadre is a small group of Senior Coroners who exist to provide advice to the Chief Coroner and expertise and operational capacity within the Coroner system to deal with mass fatality and DVI incidents. The main responsibilities, over and above those of all senior coroners, are:

- A willingness to act as an incident Coroner, for an incident in another Coroner area, if called on by the Chief Coroner to do so.
- In the event that advice or assistance is required by another Coroner or the Chief Coroner, to be available and contactable;
- Participation in the on-call rota, primarily for international deaths and incidents in tandem with police forces but also with a view to domestic events;
- Attendance at cadre training;
- To lead by example in terms of your own preparedness locally, for a DVI, mass fatality or other type of serious incident.

- In 2021 I agreed for Avon to be one of the Coroner areas involved with the pilot for the NHS Coronial Sudden Unexpected Death Programme, the pilot is looking at inherited cardiac conditions. Its aim is to prevent future deaths.

- Real time sudden death surveillance system - a partnership with Public Health started in November 2021, the aim of which is to provide data on suspected suicide, drug, alcohol and homeless deaths; its aim is also to signpost bereaved in suspected suicide deaths to organisations to help, this is all with the hope of preventing future deaths.

- Stakeholder relationships have continued to improve, over the year meetings have been held with: Bristol City Council; Avon and Somerset police; The Chief Coroner; medical examiners; hospital trusts; the crown prosecution service; the health and safety executive; Senior Coroner's across the region; the after death working group; Avon and Somerset Local Resilience Forum; Regional Disaster Victim Identification Governance.

- Security on site is in the process of being improved, and should be complete before this report is circulated and published on the website.

- Technology has been and continues to be a challenge – our current Windows 7 laptops and the desire to move to Windows 10 is not currently achievable, the problem is that the current case management and database system (Civica) which is fundamental to the work of the Coroner's office is not compatible with Windows 10/Office 365. Plans are in place to move to a web-based Civica system which will be compatible.

- Staffing – The staffing structure of the service is currently made up of the following:

    - Coroner team:
        - A full time Senior Coroner
        - One part time (.8) Area Coroner
        - Five Assistant Coroners who each sit a few days a month depending on their availability. The minimum that each sit is 15 days per annum.

    - Coroner's Officer team:
        - A full time senior coroner's officer (who also has a full case load)
        - Six full time coroner's officers

- The admin team:
  - A full time coroner support supervisor
  - Two full time coroner support administrators
  - Court ushers (2 full time and a minimum of 2 casuals)

Staff resignations have had a significant impact on the service over the last year.

The coroner's officer team has seen some significant changes leaving it significantly depleted: in December 2021 one resigned; in March 2022 another retired and in July 2022 a further officer retired. So far only one coroner's officer has been replaced starting work in April 2022.

In the admin team a coroner support administrator resigned leaving in April 2022, that member of staff has just been replaced with a start date of October 2022. During this time we have had the benefit of temporary admin support. I am advised that there was a low number of applicants which resulted in a delay to this process.

In terms of the ushers for court, one left in June 2021 and the replacement started in November 2021.

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

The plan to manage the backlog necessitated the need for a full complement of staff and the plan was for an extra full-time but temporary coroner support administrator in the admin team to assist; to date that has not been achieved due to insufficient staffing levels. The reduced level of staffing across the whole service has and will continue to impact on the recovery plan. In addition the staffing levels has meant that the investigations of all cases cannot be progressed as they should be.

A significant part of that plan was to enable three courts to be run at the same time and not just the usual two, but that plan was also dependent on having staff and therefore due to the insufficient levels of staff that has never been achieved.

- Medical Examiner (ME) system and the impact on the Coroner service – It is the impression of all staff that the cases referred by the ME to the Coroner are increasing in complexity. As complexity increases the workload of all staff increases. The ME system is expanding into the community over the coming months. The ME system was launched during the pandemic when there were other pressures and changes to the processing of deaths and therefore the impact of the ME system will be difficult to assess for some years to come.

- Jury inquests – these were not capable of being listed or heard due to their being no suitable venue to accommodate social distancing. The last jury inquest was heard at Flax

Bourton Coroner's Court in March 2020 and the next jury inquest was heard at Ashton Court in May 2021. For the period of this report i.e. April 2021 to March 2022 there have been 6 jury inquests held at Ashton Court totalling 8 weeks of court. Currently the plan is to continue to use this facility.

- Recovery from the pandemic – This continues to be the single biggest challenge to the service. At this time it is anticipated that a return to business as usual will not be achieved before 2024.

5. Coroner Statistics 2021

The statistics for Avon for the years 2006 – 2021 as compared against the national picture appear in Annex A.

Comparing coroner areas is fraught with difficulties as has been highlighted in previous reports. Also it should be noted that the statistics for 2020 cover many changes passed under the Coronavirus Act 2020 so cannot be used when making comparisons with other years.

Coroner's statistics are produced by the Ministry of Justice (MOJ) annually together with the Office for National Statistics (ONS), and for 2021 they were produced on 12th May 2022. The latest version is available to review for the whole of England and Wales by following this link:

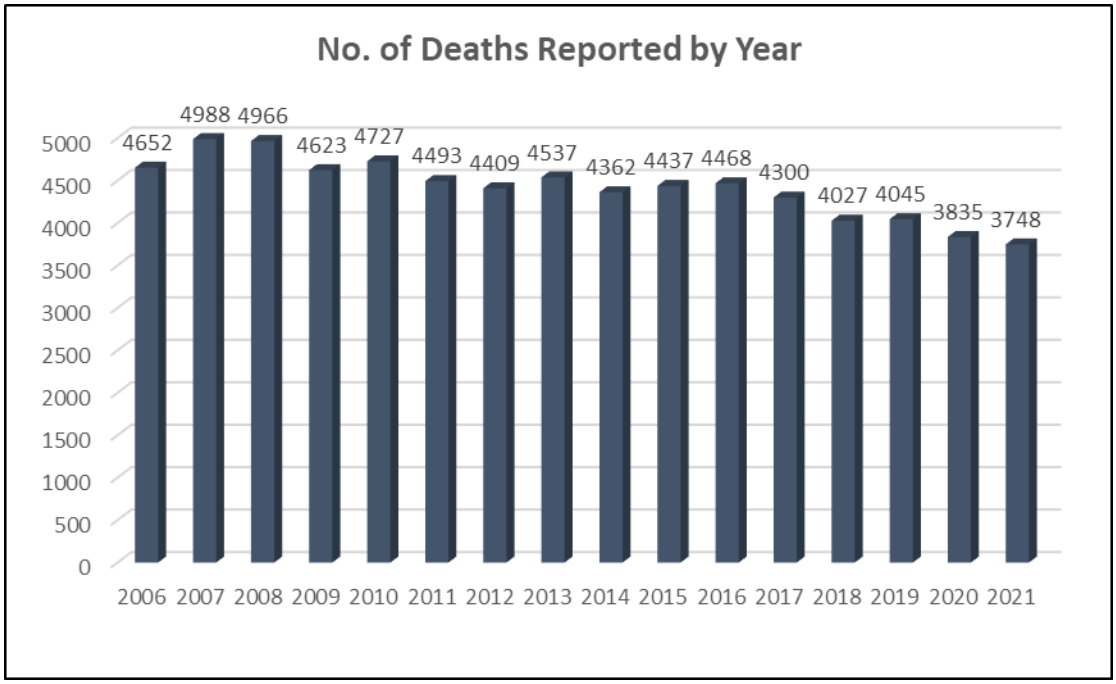
https://www.gov.uk/government/collections/coroners-and-burials-statistics

There are currently 85 Coroner areas and 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 includes greater consistency and uniformity of approach within the Coroner service. There was an opportunity locally to consider a merger with Somerset when the Senior Coroner there retired but it has been confirmed by the MOJ that merger discussions between Avon and Somerset would not progress and therefore the areas would not be merging.

Based upon the numbers of deaths reported Avon was the 7th largest area in 2021 with 3,748 (deaths reported).

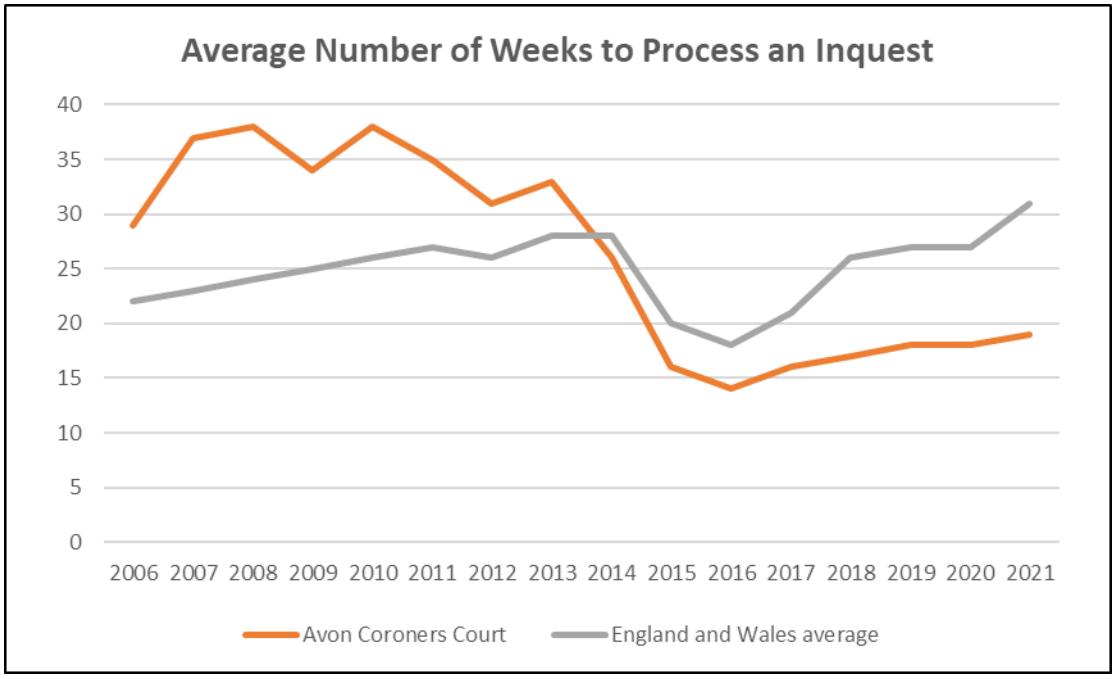
Figure 1 shows the numbers of deaths reported to Avon from 2006 to 2021.

Figure 1



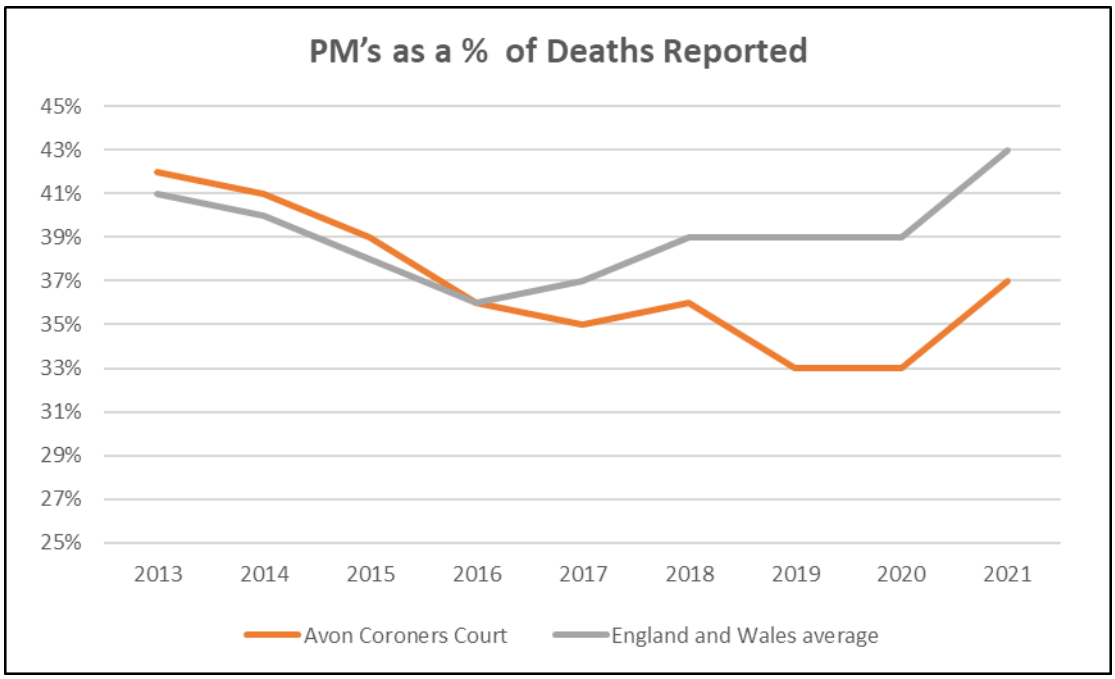
In 2021 the average time to process an inquest (from the time the death was reported to the inquest being concluded) in Avon was 19 weeks, compared to the average of 31 weeks for England and Wales over the same period, 11 weeks less than the average for England and Wales as shown in **Figure 2**.

Figure 2



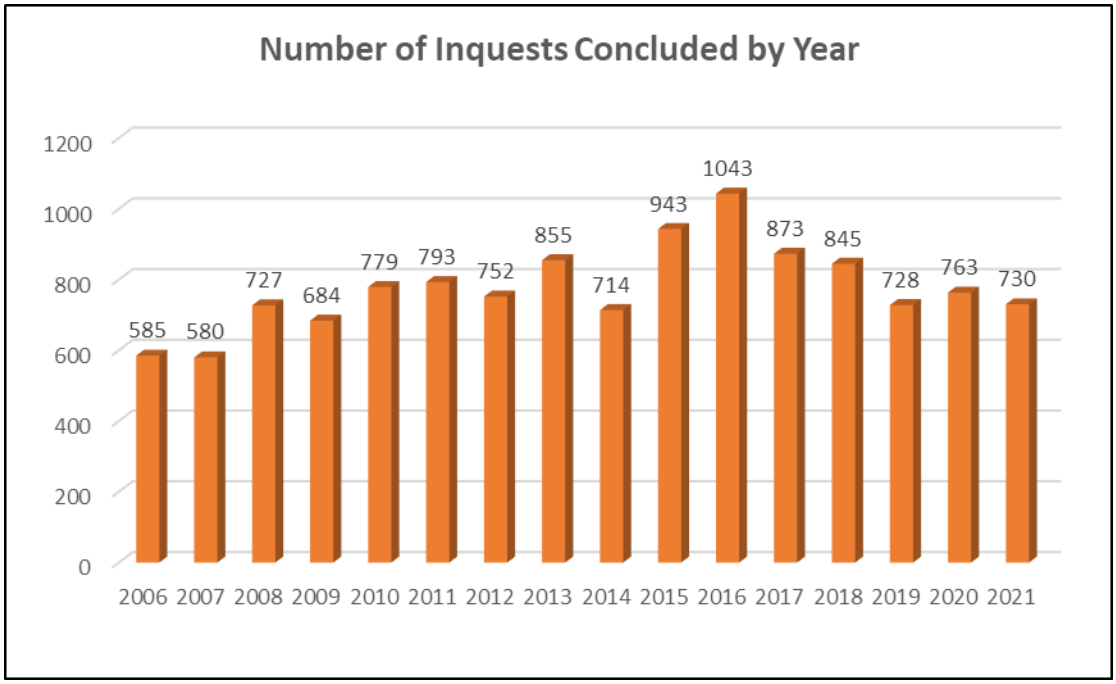
Post mortem examinations as a percentage of the number of deaths reported in 2021 in Avon was 37% with the average (mean) for England and Wales being 43%. In 2020 the figures were 38% for Avon compared with 39% for England and Wales; this is shown in **Figure 3**.

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. A significant achievement taking into account the difficulties brought about by the pandemic.
- In 2021 there were 730 inquests held in Avon of which there were 3 jury inquests, those jury inquest taking up 4 weeks of court time. In addition there were 8 inquests that lasted 5 days or more. Again a major accomplishment taking into account the ongoing difficulties brought about by the pandemic.

Figure 4



It is a requirement that senior coroners complete a notification each year around the end of April detailing those cases which have not been concluded within 12 months up to 30th April that year; 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. Some of those cases involve enquiries by other countries or other organisations 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; investigations by the accident investigation bodies or even an investigation into the death by a hospital trust. The coroner's investigation is therefore usually and appropriately put on hold pending the outcome of another organisations investigation.

Figure 5

Reason for delay	2016	2017	2018	2019	2020	2021	2022
Death abroad	1	3	3	2	1	3	3
Investigation/Prosecution by external authority	9	3	6	5	14	10	14
Complex case	2	2	2	5	8	1	11
Prepared for inquest			1	3	6		
Current criminal proceedings in the Crown Court				6	3	18	5
Covid-19						29	22
Total cases over 12 months old	**12**	**8**	**12**	**21**	**32**	**61**	**55**

What should be noted is that since the report was produced in April 2021 44 of the cases which appeared on the 2021 report as being over 12 months old have been completed, the result of a significant effort by all concerned. Furthermore of the 55 cases in the 2022 report 22 are effectively out of my control (deaths abroad, investigation/prosecution by external authority and current criminal proceedings in the Crown Court).

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 2021 are detailed in Annex B. There were 3 reports written in 2021 following the inquests of: Jerome Alexander Peat; Anastasia Ekaterina Uglow and Maria Stancliffe-Cook.

7. Future Developments:

The plans at this time continue to include:

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

But in addition will also include:

- Moving to the cloud based civica system with the roll out of Windows 10/Office 365
- The medical examiner system will be moving into the community, the impact of that on the Avon Coroner and indeed all Coroners is yet to be assessed but will be a significant development over the coming year(s).

To achieve this there needs to be sufficient staffing to carry out the work and the provision of suitable accommodation.

Acknowledgements

The senior coroner wishes to thank all the team for their continued commitment and immense effort in delivering a service in often challenging circumstances.

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
2021	3748	19	31	692	730	18%	17%	1388	37%	43%
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 3 reports written in 2021 following the inquests of:

- Jerome Alexander Peat,
- Anastasia Ekaterina Uglow and
- Maria Stancliffe-Cook.

Redacted extracts from those reports appear below.

1. Deceased name: Jerome Alexander Peat

Date of report: 4th February 2021
Report sent to: Long Furlong Medical Centre
Report by: Dr Simon Fox QC

INVESTIGATION and INQUEST

On 04/03/2020 an investigation was commenced into the death of Jerome Alexander Peat. The investigation concluded at the end of the inquest on 03/02/2021. The conclusion of the inquest was that the death was "Drug Related" and I found that Mr. Peat died from an overdose of prescribed medication, including morphine.

CIRCUMSTANCES OF THE DEATH

Mr. Peat was prescribed morphine by Long Furlong Medical Centre on 4.11.19, by the Student Medical Centre in Bristol on 5.11.19 + 21.11.19 and by the out of hours doctor in Bristol on 1.12.19. He was found dead from an overdose of morphine on 12.12.19 at his student accommodation.

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. –

The EMIS computer medical record on 4.11.19 failed to alert Dr [redacted] at Long Furlong Medical Centre that Mr. Peat had already registered with the GP at the Student Medical Centre, as a result of which there was inadvertent duplication of his morphine prescription on 4.11.19 and 5.11.19 and Mr. Peat was prescribed significantly more morphine than was intended. He subsequently died from an overdose of prescribed morphine.

2. Deceased name: Anastasia Ekaterina Uglow

Date of report: 20th May 2021
Report sent to: The Secretary of State for Education
Report by: Maria Voisin

INVESTIGATION and INQUEST

On 20/05/2020 I commenced an investigation into the death of Anastasia Ekaterina UGLOW. The investigation concluded at the end of the inquest 14th May 2021. The conclusion of the inquest was …

Anastasia Uglow died on 19th December 2019 at Mount Sinai Hospital, New York. She was in New York on a school trip from her home in Bristol. She had been unwell in the days leading up to the trip, but became worse as the days progressed. She had influenza with pneumonia and group A streptococcus. On 18th December 2019 she participated in the trip in the morning, went shopping in the afternoon and went on a trip to the Empire State Building in the evening. On 19th December 2019 in the morning she woke in septic shock; she collapsed in cardiac arrest; the emergency services were called but she died when she arrived at the hospital.

CIRCUMSTANCES OF THE DEATH

Ana had been unwell before her trip with the school but it was when she was on the trip in New York when she became more unwell. To those around her she had cold/flu like symptoms. It was reported that she told the teachers on the trip about not feeling well. She had sepsis, deteriorated and collapsed in her hotel room.

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 it became clear that Ana's school is already taking the step to include within their first aid training for staff – sepsis awareness.

This case clearly demonstrates how awful this condition is and how tragic the consequences are if it left untreated.

My report is therefore written to consider raising sepsis awareness within all schools.

At the conclusion of the inquest I requested that Ana's school provide any additional information which may assist with this and they have emailed the following ….

"I wonder if you would be kind enough to pass this email to H M Senior Coroner. It is response to her request that [redacted] Grammar School) assist in relation to her proposed PFD report to raise awareness of sepsis in schools.
We respectfully submit that the Coroner should write to the Secretary of State for Education and ask him to draw the attention of the DfE Health and Safety team to her proposed PFD report. ..
The ability of a healthy teenager to compensate for sepsis symptoms is frightening and [redacted] is determined to do all it can to raise awareness of this issue with the aim of preventing any future tragedies.
[redacted] has secured the agreement of the Outdoor Education Advisers' Panel (OEAP) and the UK Sepsis Trust that they will produce a guidance document on SEPSIS awareness and add this to the OEAP National Guidance website (https://oeapng.info/). [redacted] and [redacted] (the Headmaster of [redacted]) and [redacted] staff first aid trainer) are currently liaising with the UK Sepsis trust. Dr [redacted] of the Sepsis Trust and Dr [redacted] have met recently and discussed the nature of this guidance and have also suggested that in addition to written guidance they will produce a short video for use in training School staff and there will be a link to this in the OEAP guidance document. [redacted] will fund the production of this guidance by donation to the UK Sepsis Trust and the ongoing cost of keeping it updated through an annual contribution to the OEAP. The OEAP guidance document will be produced and available to Schools for the start of the Autumn Term 2021. We are looking to launch the guidance to coincide with World Sepsis day on 12 Sept 2021 in order to gain the maximum publicity. We would hope that the OEAP guidance document will then be something the DfE and other organisations could then to 'signpost to' in their own advice. DfE Health and safety Guidance for School visits currently signposts to OEAP Guidance in general – see point 8 in https://www.gov.uk/government/publications/health-and-safety-on-educational-visits/health-and-safety-on-educational-visits OEAP guidance is also endorsed by the HSE (see https://oeapng.info/endorsements/)
[redacted] will promote the guidance document to Independent School organisations – HMC, ISC, GDST, ISBA. The OEAP will promote the new guidance to all Schools through its twitter and facebook accounts and the network of advisers to maintained schools and the UK Sepsis Trust will promote it through a campaign. "

3. Deceased name: Maria Stancliffe-Cook

Date of report: 8th July 2021
Report sent to: Avon and Wiltshire Mental Health Partnership NHS Trust and Minister for Patient Safety, Suicide Prevention and Mental Health
Report by: Maria Voisin

INVESTIGATION and INQUEST

On 21/08/2019 I commenced an investigation into the death of Maria STANCLIFFE-COOK. The investigation concluded at the end of the inquest.

Box 3 of the record of inquest recorded the following: "Maria Stancliffe-Cook died on 1st August 2019 at 1 Highbury Villas, Cotham, Bristol. She had intentionally taken her own life with the use of helium causing asphyxiation. She had been assessed by the mental health team on 26th July 2019 and her risk had been downgraded from high to medium. She had a telephone call on 28th July 2019 which did not meet the standard; there was no assessment or plan to manage her risk undertaken at this time."

The conclusion was: suicide contributed to by neglect.

CIRCUMSTANCES OF THE DEATH

Maria had a history of poor mental health over many years which resulted in a referral to the mental health team in January 2018.

On 18th December 2018 Maria was admitted to A&E at [redacted] having tried to end her life by using helium, and was referred to crisis team who later discharged her back to the care of her GP.

On 23rd January 2019 her GP said that Maria told her that she'd ordered another helium kit, she denied any thoughts and was referred to the mental health team.

From then until the events in July there are various appointments with the mental health team, her GP and her therapist.

On 12th June 2019 there was a meeting with a number of those caring for Maria the notes say

" we expressed our worry with Maria that with the method which she had considered in the past her ongoing social isolation and the sense that it is unlikely she would ask for help from others she would be a high risk of completed suicide if she attempted again. Her lack of protective factors beyond her investment in her studies was also discussed "

Her care coordinator [redacted] was present and she said in her evidence that was read, “We were concerned about the ongoing risk of completed suicide given she continued to be in possession of a helium bottle, the risk was not considered to have changed since my first meeting with her when the risk to self was recorded as high”.

By 26th July 2019 things significantly changed. She reported to her therapist and GP both who knew her well that she was having active suicidal thoughts. She had told them both that she’d tried to use the helium cylinder but it failed so ordered another one; she also said that she’d been researching high buildings. Her therapist was extremely concerned and said that that this felt like she had a high intention to complete suicide. He reported this to the mental health team.

Her GP said that this was a big change; Maria told her that her suicidal thoughts had got worse and they were difficult to dismiss. Her GP referred her to the mental health team explaining her concerns.

Maria was seen that evening by two members of the mental health team neither of whom had met her before. They assessed her and decided to downgrade her risk from high to medium.

On 28th July 2019 as planned one of them telephoned Maria, this was Maria’s last contact with anyone from the mental health team the call and the note making lasted around 3 minutes, she said that Maria told her she was ok.

Sadly on 1st August 2019 – Maria was found dead by police after flat mates became concerned for her. That week she was also supposed to have an appointment with a care coordinator but that had not been arranged.

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. –

The trust have themselves admitted the failures reflected in an independent report they commissioned after the death, that report said “we would not expect a patients level of risk to be downgraded from high … to medium immediately following a suicide attempt”; In addition I heard evidence in relation to the assessment on the 26th July 2019 when the risk was downgraded from high to medium.

I listened very carefully to the steps that the Trust has taken to make changes following this death and I am pleased that a number of changes have taken place. I raised my concern about the downgrading of risk from high to medium in this case by two members of the team that had no previous dealings with Maria.

Maria was well known to the trust and her own care coordinator said “We were concerned about the ongoing risk of completed suicide given she continued to be in possession of a helium bottle, the risk was not considered to have changed since my first meeting with her when the risk to self was recorded as high”. That was a reference to a multidisciplinary meeting which took place a matter of weeks before her death.

I was told that risk is dynamic and that professionals assess risk at the time and that it can go up and down. I was also told that there are lots of assessments by staff that do not know patients. That said there is a concern that there is a risk of future death - is it right that the risk of a patient, who is well known to the trust, with a care coordinator who knew her well, is downgraded without any check put in place.