Maria Eileen Voisin

HM Senior Coroner for the Area of Avon

Annual Report

2022/2023

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1. Introduction

This report for the Coroner area of Avon, covers the period from approximately April 2022 to March 2023.

However, due to the timing of when national statistics are produced, the report considers those for the year 2022. Those annual statistics show 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 2023.

The report also reviews what progress has been made in what continues to be a challenging time for Coroner's and what the future developments are for Avon.

Finally, the important role of a Coroner includes making recommendations to appropriate organisations to prevent future deaths. This report includes details of the recommendations made during 2022.

2. Role of the Coroner

The role of the Coroner is to answer 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.

A Coroner is a judge 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 area, 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:

- To manage the backlog of cases arising from Covid, whilst maintaining standards.

- The desire to return to business as usual performance.
- Moving to the cloud based Civica case management system, with the roll out of Windows 10/Office 365
- The medical examiner system moving into the community and the impact that would have.

As can be seen within this report, the single most significant challenge is still the enormous workload of reported deaths and inquests outstanding. You will see from the statistics in Annex A that there has been a significant amount of work achieved by the team, that said the desire to manage the backlog and return to business as usual is some way off at this time.

We successfully moved to the Civica Cloud based system in January 2023 which overall is generally working well.

The medical examiner system locally is still expanding into the community. In April 2023, the Government indicated that the statutory medical examiner system will be introduced from April 2024. The introduction of this will continue to impact on the Avon Coroner's service for years to come. This is likely to result in a decrease of the straightforward enquiries, as these will probably be managed by the medical examiner's office. However, it is also likely to result in an increase of the more complex medical deaths.

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

- 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. This pilot is still operating.
- Stakeholder meetings have continued, with meetings having been held with: Bristol City Council; Avon and Somerset police; The Chief Coroner; medical examiners; hospital trusts; Senior Coroner's across the region; Avon and Somerset Local Resilience Forum and Regional Disaster Victim Identification Governance.
- Security on site at Flax Bourton is in the process of being improved and will be complete before this report is circulated and published on the website.
- Staffing – The staffing structure of the service is currently as follows :
    - Coroner team:
        - A full time Senior Coroner
        - One part time (.8 FTE) Area Coroner
        - Five Assistant Coroners who each sit a few days a month depending on their availability. The minimum that each is required to sit is 20 days per annum.

    - Permission has been given to recruit another one Assistant Coroner

- Coroner's Officer team:
    - A full-time senior coroner's officer (who also has a full case load for the Avon area and who also supervises Somerset coroner's officer team)
    - Six full time coroner's officers

- The admin team:
    - A full-time coroner support supervisor
    - A full-time inquest and coroner support administrator
    - A full time coroner support administrator (and 1 temporary casual)
    - Court ushers (2 full time and a minimum of 3 casuals)

Staff turnover with resignations and a retirement continued to have a significant impact on the service over the last year. In effect there was a time when of the seven coroner's officers we only had five in post. This impacted on the team from December 2021. It has only been since March 2023 that we have had all seven coroner officer posts filled.

In the admin team a new member of staff joined in November 2022 following a resignation in April 2022. During that time, we have had the benefit of some temporary admin support.

To enable the team to manage the caseload, a full complement of staff is required at all times, this is only now in place. The reduced level of staffing over such an extended period continues to impact on managing the workload and addressing the backlog.

- The numbers of cases and the complexity of cases is increasing – The reasons for this are multifactorial including:

    - The requirement that a doctor must have attended in the last illness to enable them to complete a Medical Certificate as to the Cause of Death (MCCD). Less GP's are able to issue MCCD's as they have not attended the patient in their last illness, because of this a referral to the Coroner is required. This may also result in a post-mortem and investigation with or without an inquest.

    - Medical Examiner (ME) system – the cases that are referred by the ME to the Coroner can be more medically complex.

    - An increase in families who seek legal advice and representation at inquests. Most Coroner's are of the view that this results in a more complex investigation.

    - The increased availability of funding for some inquests including legal aid.

    - An increase in the number of families raising concerns about the circumstances contributing to the death.

    - An increase in the number of families attending inquests.

- ➢ An increase in the number of experts instructed.
- ➢ An increase in the number of longer inquests with more witnesses being called to attend and give evidence.

- Jury inquests – During the pandemic there were no jury inquests completed due to the size of the existing court and jury facility at Flax Bourton (March 2020 -April 2021). A court was set up at Ashton Court (at an additional cost) to enable jury inquests to be heard. For the period April 2021 to March 2022 there were 6 jury inquests held at Ashton Court totalling 8 weeks of court time. In addition, Ashton Court was used to enable the listing and completion of a complex 4 week inquest.
- Recovery from the pandemic – Previous reports have indicated that the return to business as usual will not be achieved before 2024. This is still the case but there is now the additional concern of workload and complexity of cases increasing, essentially which means that the business as usual cannot ever be achieved with the current staffing levels, as the workload has fundamentally changed for Avon Coroner's service. It is only due to the dedication of an incredibly hardworking and professional team that the standards of the service have been maintained.

5. Coroner Statistics 2022

The statistics for Avon for the years 2006 – 2022 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, recent years have been impacted by changes in the law passed under the Coronavirus Act 2020 so care should be taken when making comparisons with previous years.

Coroner's statistics are produced by the Ministry of Justice (MOJ) annually together with the Office for National Statistics (ONS), and for 2022 they were produced on 11th May 2023. 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

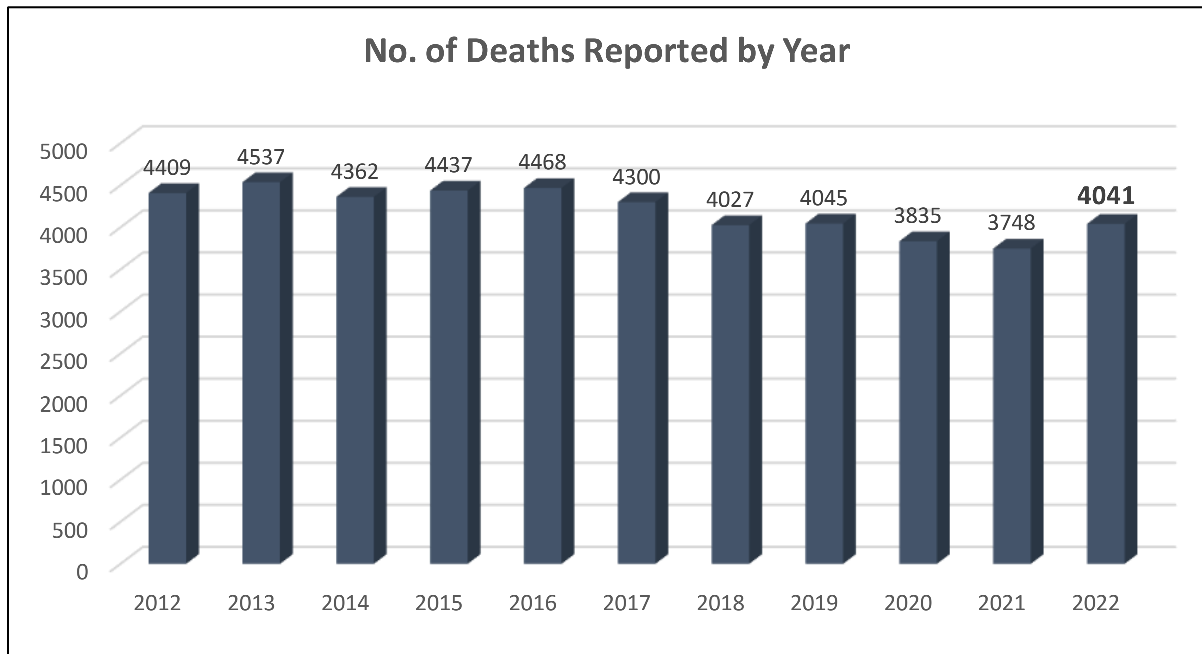
There are currently 83 Coroner areas 2 less than last year due to mergers.

Based upon the numbers of deaths reported Avon was the 8th largest area in 2022 with 4,041 (deaths reported).

There has been an 8% increase in the number of deaths reported to Avon in 2022, that is 293 more deaths reported, compared with those reported in 2021.

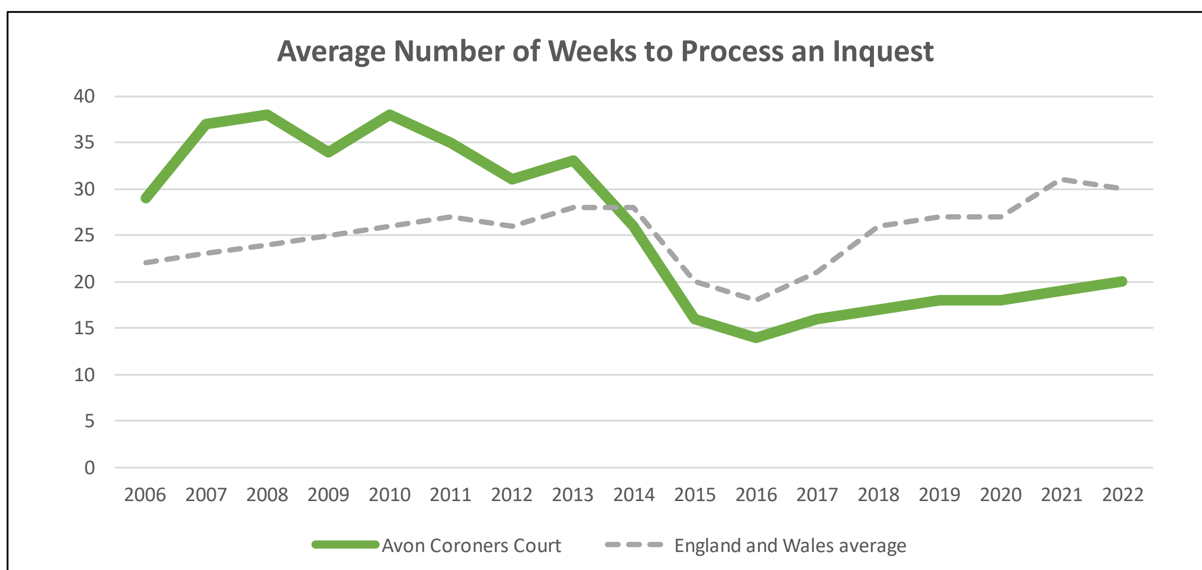
Figure 1 shows the numbers of deaths reported to Avon from 2006 to 2022.

Figure 1



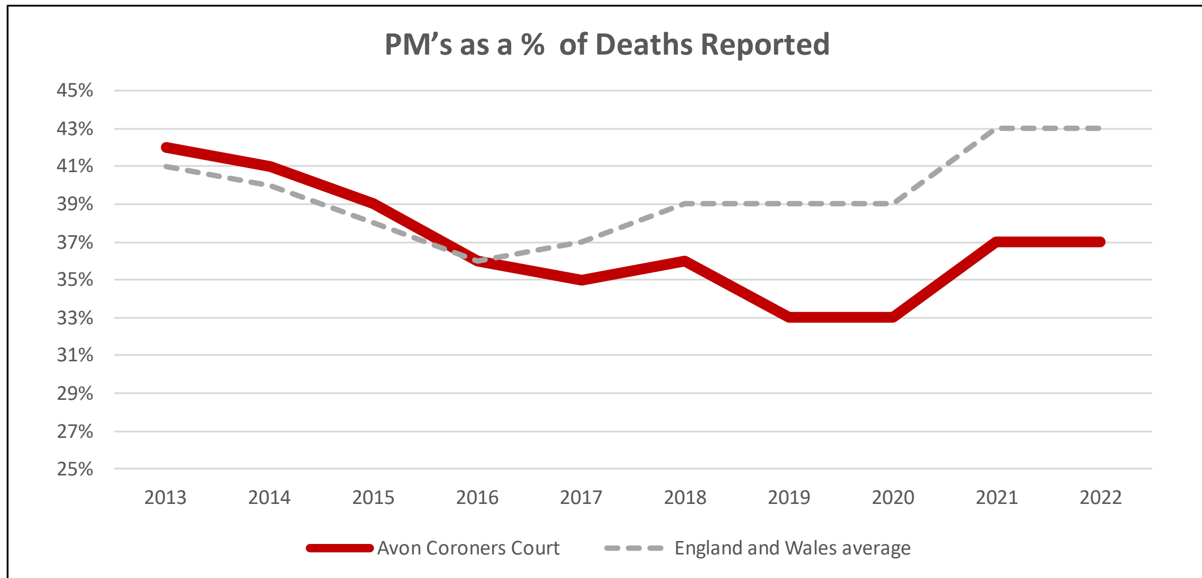
In 2022 the average time to process an inquest (from the time the death was reported to the inquest being concluded) in Avon was 20 weeks, compared to the average of 30 weeks for England and Wales over the same period as shown in **Figure 2**. It appears that from 2016 the time taken to process an inquest has been increasing for England and Wales (including the Avon area).

Figure 2



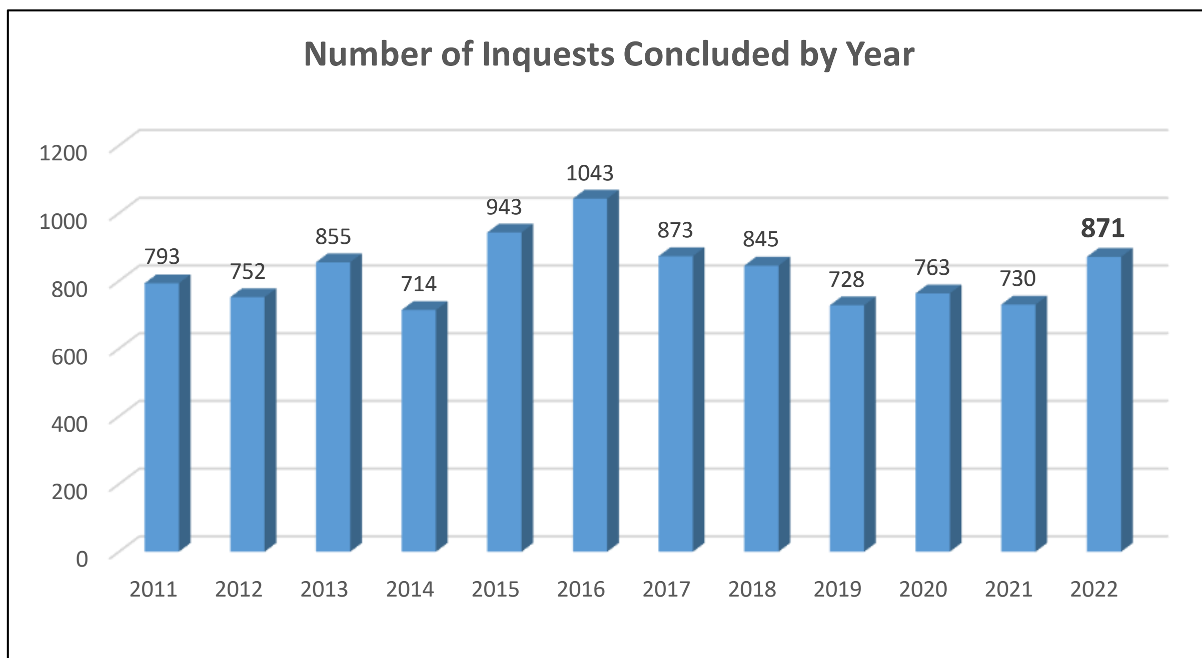
Post-mortem examinations as a percentage of the number of deaths reported in 2022 in Avon was 37% with the average (mean) for England and Wales being 43%, this is shown in **Figure 3**. These figures are the same as last year.

Figure 3



In 2022 there were 871 inquests held in Avon, 730 in 2021. It should be noted that between April 2022 and March 2023 there were also 10 jury cases heard, totalling 10.5 weeks of court time **Figure 4**.

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 the end of 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 some acceptable reasons why a case is outstanding, for example: an ongoing police investigation; a criminal prosecution; a death abroad; Health and Safety Executive or Prison and Probation Ombudsman inquiries; investigations into the death by a hospital trust. The coroner's investigation is therefore appropriately put on hold pending the outcome of another organisation's investigation.

Figure 5

Reason for delay	**2016**	**2017**	**2018**	**2019**	**2020**	**2021**	**2022**	**2023**
Death abroad	1	3	3	2	1	3	3	**2**
Investigation/ Prosecution by external authority	9	3	6	5	14	10	14	**18**
Complex case	2	2	2	5	8	1	11	**26**
Prepared for inquest			1	3	6			**22**
Current criminal proceedings in the Crown Court				6	3	18	5	**7**
Covid-19						29	22	**2**
Total cases over 12 months old	**12**	**8**	**12**	**21**	**32**	**61**	**55**	**77**

Of the 77 outstanding cases over 12 months old as of 28th April 2023, 24 are listed with a final inquest date. 27 of those 77 cases are outside of my control being: deaths abroad (2), investigation/ prosecution by external authority (18) or current criminal proceedings in the Crown Court (7). There has in addition, been a huge effort by all staff to ensure that the numbers of older cases are managed but this is challenging when there has been a protracted period of reduced staffing levels.

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 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 2022 are detailed in Annex B. There were 7 reports written in 2022.

7. ***Future Developments:***

The plans currently include:

- The ongoing management of an increased and more complex caseload whilst maintaining standards. To achieve this there needs to be a stable workforce with the provision of suitable accommodation.
- Currently, the proposal is that the use of Ashton Court will cease from April 2024. This is likely to have a knock-on effect in managing the increased complex caseload due to the limitations at Flax Bourton Coroner's Court. It is likely that once the use of Ashton Court stops that cases will be delayed due to the lack of availability of a suitable courtroom to hear them. There are already seven jury cases which need to be listed from April 2024 – April 2025 and this number will only increase. Court accommodation needs to be reviewed to enable the workload to be managed.
- The medical examiner system is slowly 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).
- The process for managing a death in the community, out of usual business hours, is being reviewed (the details of which fall outside of this report), the exact impact of this is unclear at the time of writing.
- The system for reporting a death to the Avon team is changing; it is hoped that there will be a portal for professionals to use when making that referral. There will be a link from the Avon Coroner's website for them to use. The aim is to avoid delays for families; for it to be a simpler process for professionals and to save time.

Acknowledgements

The senior coroner wishes to thank all the team for their continued commitment and immense effort in delivering a service in what has been a very busy and challenging 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
2022	**4041**	**20**	**30**	**784**	**871**	**19%**	**17%**	**1506**	**37%**	**43%**
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 7 reports written in 2022 following the inquests of:

- Reginald Howard Weston
- Susan Elizabeth Carling
- Donald Gore
- Gerwyn John REES
- Michael Elliott
- Ami Louise Mitchell
- Celia Lindsey Marsh

Redacted extracts from those reports appear below.

1. Deceased name: Reginald Howard Weston

Date of report: 11th January 2022
Report sent to: Management, Blenheim House Care Home
Report by: Myfanwy Buckeridge

INVESTIGATION and INQUEST
On 04/08/2021 I commenced an investigation into the death of Reginald Howard Weston. The investigation concluded at the end of the inquest. The conclusion of the inquest was Accident.

CIRCUMSTANCES OF THE DEATH
Mr Weston died due to injuries sustained in a fall on 7 July 2021. It was identified in evidence that he had moved and bypassed the sensor mat that had been placed at his feet and that care staff were aware he had done so on previous occasions. Although the presence of an in-place sensor mat unlikely made a difference in Mr Weston's fall, it may do so in different circumstances where a resident is known to bypass the sensor mat. He had fallen twice on 4 July 2021 but there was no evidence to indicate his falls risk assessment was reviewed following those falls and recorded as required by the Majisticare Falls Management Policy and Procedure.

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. –

Evidence was given in relation to the Majesticare Falls Management Policy and Procedure requirement to record a review of the resident's risk assessment in the context of 2 recorded falls on 4 July 2021. Blenheim House management need to consider:

a) Documentation demonstrating a review of the resident's risk assessment has taken place following a fall

b) Timely process for completing it

2. Deceased name: Susan Elizabeth Carling

Date of report: 28th April 2022
Report sent to: Royal College of General Practitioners; British Medical Association; The Minister of State for Patient Safety, Suicide Prevention and Mental Health
Report by: Maria Voisin

INVESTIGATION and INQUEST

On 02/02/2022 I commenced an investigation into the death of Susan Elizabeth Carling. The investigation concluded at the end of the inquest 27th April 2022. The conclusion of the inquest was that of suicide.

CIRCUMSTANCES OF THE DEATH

Susan was a General Practitioner she died on 2nd January 2022 at her home address. She was found hanging in the loft.

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. –

Her family brought to my attention that there are approximately 100 people in the health service who commit suicide each year. They requested that in my role to prevent future deaths that this is considered by someone who could potentially take action to prevent future deaths in this profession going forward.

I am aware and made it clear to the family that there are organisations that GP's can access for support however they like I agree that this needs to be highlighted if suicides are to be prevented in this vulnerable professional group.

3. Deceased name: Donald Gore
Date of report: 17th June 2022
Report sent to: Air Balloon Surgery
Report by: Simon Fox

INVESTIGATION and INQUEST

On 08/04/2020 I commenced an investigation into the death of Donald Gore. The investigation concluded at the end of the inquest on 17/6/22 . The conclusion of the inquest was -
Natural Causes contributed to by neglect.

CIRCUMSTANCES OF THE DEATH

Mr Gore acquired Mycobacterium Chimaera infection from the aerosol produced by a Liva Nova heater cooler unit used in association with a heart bypass machine during open heart surgery at Bristol Royal Infirmary on 16th November 2016.

Mr Gore presented with symptoms of Mycobacterium Chimaera infection from November 2017 - 12 months after the operation at which he contracted it. There was a delay in diagnosis of the infection until just 3 weeks before his death 21 months later, during which time he was assessed by numerous clinical staff in both primary care and in hospital and as both an inpatient and outpatient.

The reason for the delay in diagnosis was that Mr Gore did not receive appropriate medical management in the following respects -

a) In March 2017 the cardiac surgery department did not send Mr Gore the standard letter to patients advising him of the risk of Mycobacterium Chimaera infection;
b) In November 2017 the General Practitioner to whom he first presented with symptoms did not read the alert regarding the risk of Mycobacterium Chimaera infection contained in his GP records, entered in March 2017 further to a letter sent to the practice by the cardiac surgery department, or advise hospital doctors of his risk of Mycobacterium Chimaera infection;
c) Hospital doctors, in particular in infectious diseases/microbiology and cardiology, who saw Mr Gore on numerous occasions from November 2017 onwards were unaware of the risk (from their own knowledge or from Mr Gore's hospital records) or did not recognise the risk of Mycobacterium Chimaera infection and did not test for it until July 2019 - 4 weeks before he died;
d) When requests were eventually made for tests on cerebrospinal fluid or blood cultures for Mycobacterium Chimaera infection, these were not acted upon or were delayed.

During the delay Mr Gore was misdiagnosed with sarcoidosis, as a result of which he was treated with long term steroids which may have accelerated his Mycobacterium Chimaera infection or made it more severe.

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 evidence demonstrated that the General Practitioner to whom Mr Gore first presented with symptoms on 3.11.17 did not read the alert regarding the risk of Mycobacterium Chimaera infection contained in his GP records, entered in March 2017 further to a letter sent to the practice by the cardiac surgery department.

The investigation in response to this is summarised in a document headed *"Proforma for completion at SEA/adverse incident meeting"* dated 14.11.9.

My concerns are -

1. The investigation in response to this incident summarised in that document -

a) Does not conform to the usual detail and format of such investigations (eg a Root Cause Analysis), and
b) Appeared inadequate;

(In addition the investigation and document, or even their existence, were not disclosed to the Coroner's office despite three GP statements/reports from your practice being requested and provided in the preparation for the Inquest, only being revealed in the course of oral evidence from the GP during the course of the Inquest).

4. Deceased name: Gerwyn John REES

Date of report: 8th August 2022
Report sent to: Chief Executive, University Hospitals Bristol and Weston NHS Foundation Trust ('UHBW'); Head of Clinical Governance, UHBW
Report by: Robert Sowersby

INVESTIGATION and INQUEST

On 30 h October 2018 an investigation commenced into the death of Mr Gerwyn John REES, aged 77. The investigation concluded at the end of the inquest on 3 August March 2022.

The medical cause of death was:

1a) Frailty and hip fracture
2)Delirium

The narrative conclusion of the inquest was as follows:

Mr Gerwyn Rees was elderly and frail, and at a high risk of sustaining serious injury from falling, when he was admitted to the Bristol Royal Infirmary on 28 November 2020. The staff looking after him in hospital did not take adequate steps to prevent him from falling, and he fell over on 29 November 2020, sustaining a fractured hip. He underwent surgery, but his condition continued to deteriorate over time, and in January 2021 he was discharged to Westin Care Home in Whitchurch for palliative care: he sadly died there on 17 January 2021, as a result of both general frailty and the hip injury sustained in hospital.

CIRCUMSTANCES OF THE DEATH

- Mr REES was 77 years old and was in poor general health
- He had a pre-existing brain injury, frontal lobe damage, a history of alcohol misuse and a significant psychiatric history
- He experienced episodes of confusion and had memory problems
- He mobilised at home with a stick or with a frame, or with assistance
- Before the admission during which he broke his hip, Mr REES had a recent *previous* admission (from October to 25 November 2020), during which he had been investigated for gallbladder problems – an admission that he had not been expected to survive
- I note from the RCA report that Mr REES had experienced an inpatient fall (at Callington Road Hospital) immediately prior to that admission, and further inpatient falls (at the BRI) during it
- Mr REES had been discharged home from that earlier admission on 25 November 2020
- While he was at home he appears to have had a number of falls over the ensuing days, and on 28 November 2020 (just three days after his discharge) he and his partner called 999
- When the ambulance attended, the paramedics determined that Mr REES had postural hypotension (which meant he was often dizzy or lightheaded when he stood up); they were also concerned that he may have a heart condition, and were worried that he appeared not to be looking after himself
- The paramedics took Mr REES to the BRI, where he was admitted the same day

- The following day (29 November 2020) Mr REES had his falls risk assessed on Ward A413
- That assessment was carried out by a Nursing Assistant, and then signed off by a Registered Nurse
- At that time falls risk assessments were performed in line with the BRI's then-current Enhanced Care Observation and Meaningful Observation Policy ('the ECO Policy')
- In my judgment, when his falls risk was assessed on 29 November 2020 Mr REES clearly and unarguably represented a high falls risk – there was a significant risk that he would fall, and a very significant risk that if he did fall, then he might sustain serious injury
- To reiterate, at the time of that assessment Mr REES was:
    - 77 years old
    - Frail and appeared not to be looking after himself
    - Mobilised with a stick or a frame, or with help, when he was at home
    - Had fallen at least once, and possibly more than once, in the last 3-4 days
    - Had fallen more than once during his last (recent) inpatient stay at the BRI
    - Had a known brain injury (which both made him particularly vulnerable if he did fall, and also contributed to episodes of confusion and memory loss)
    - Had been admitted with identified postural hypotension, which created an obvious falls risk.
- Notwithstanding those obvious (and significant) risk indicators, Mr REES was assessed as requiring Level 2 Enhanced Care Observations: I note from looking at the relevant table in Appendix A of the then-in-force ECO Policy that this equates to a "low risk"
- According to the text accompanying "ECO level 2", that level of observations is to be used when:

    *"The patient displays occasional unsafe behaviour (**which is not expected to result in serious harm**) or is at avoidable risk **of mild levels of harm**."*

  (Emphasis in bold added.)
- The wording in this part of the table contains two distinct elements: the first relates to the likelihood of a fall taking place, the second relates to the likely seriousness of the outcome if a fall does happen
- It appears self-evident to me that a frail 77-year old with a pre-existing brain injury is at risk of really serious harm if s/he falls over in hospital, and therefore that ECO level two could not in any way be an appropriate categorisation for someone in Mr REES's position, irrespective of whether he could properly be said to exhibit only occasional unsafe behaviour
- Mr REES had his first inpatient fall later that same day – at around 12.30pm – although he did not sustain any serious injury at that time
- He was then transferred to ward A515
- I was told in live evidence that Mr REES's falls risk had been reassessed after his first inpatient fall, and that he was moved to A515 as an "ECO level 3" patient,

although that evidence was not supported by the contemporaneous medical records, or indeed by much of the written evidence that was submitted to me in the course of my investigation

- Shortly after moving to Ward A515 Mr REES was left unattended by the Nursing Assistant who was supposed to be keeping an eye on him (she had gone to tell the Nurse in Charge that she thought he needed to be observed more closely); Mr REES tried to stand up to follow her out of the room, suffered his second inpatient fall of the day, and fractured his hip (an injury which later made a significant contribution to his death)
- Although Mr REES underwent successful surgery, he never recovered fully from this injury, and he later died as a result of both his frailty and the fracture.

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. –

- I find it very difficult to see how Mr REES could properly have been allocated to level 2 ECO observations ("low risk") at the time of his initial falls risk assessment on 29 November 2020
- However, notwithstanding that initial concern on my part, I am more concerned by the apparent absence of learning following Mr REES's death
- The Trust's Root Cause Analysis ('RCA') investigation/report (co-authored by [REDACTED], a Matron / Senior Nurse) does not identify any issue or concern in respect of that initial allocation to ECO level 2
- Further – during the inquest – when I questioned the nurse who had approved the initial "Level 2" allocation on Ward A413 [REDACTED] she initially maintained that ECO Level 2 was appropriate for Mr REES at that time, before later conceding to me that he should have been allocated to Level 3 observations from the outset and that ECO Level 2 was not an appropriate categorisation for him at the time of his initial falls risk assessment
- When I then questioned [REDACTED]r) (RCA co-author) about this same point, she too initially gave evidence that ECO Level 2 was a reasonable categorisation for Mr REES during the initial falls risk assessment, applying "*clinical judgment*" (albeit that she later accepted – I think – that it had not been an appropriate categorisation at that time)
- I struggle to see how, as a senior nurse with responsibility for investigating an incident such as this and disseminating learning as a result of it, can have suggested to me that ECO 2 was ever appropriate for Mr REES
- The lack of criticism of Mr REES's initial risk allocation to ECO level 2 in the RCA report, coupled with these aspects of the live evidence of Nurse and

Matron (see above) suggest to me that either there was a lack of investigative rigour in the RCA reporting process, or that the ECO Policy was (and is) not properly understood by the staff involved in authoring the RCA, or in implementing the policy

- Whilst it is relatively commonplace to see circumstances in which policies or standard operating procedures have not been properly understood or implemented on a ward, in real time, it is more concerning still to see circumstances such as these; in which even after the Trust's investigation and learning process have been completed there does not appear to be an appreciation of where mistakes have been made: this of course means that there has been a missed opportunity to learn from the death in question
    - For completeness, I do not think that I am wrong in my interpretation of the ECO Policy, but if I am, and if – following that policy properly – a patient with a background such as Mr REES could properly be described as at "low risk" and requiring only the protection that is afforded by ECO level 2, then I would be very concerned that the policy itself was not fit for purpose, or safe.

5. Deceased name: George Michael Elliott

Date of report: 4th October 2022

Report sent to: Chief Executive, North Bristol NHS Trust and Head of Clinical Governance / Clinical Governance Lead, North Bristol NHS Trust

Report by: Robert Sowersby

INVESTIGATION and INQUEST

On 13 September 2021 an investigation commenced into the death of Mr George Michael ELLIOTT, aged 81. The investigation concluded at the end of the inquest on 20 September 2022.

The medical cause of death was:
1a) Traumatic brain injury
1b) Fall in hospital
2)Coronary artery disease

The conclusion was that this was an accidental death, and the brief circumstances of the death were recorded as follows:

On 4 September 2021 George Michael Elliott was an inpatient at Southmead Hospital, receiving investigation and treatment for an underlying cardiac condition, when he fell, sustaining a serious brain injury. Unfortunately his condition deteriorated some days later, and on 9 September 2021 he died in hospital as a result of the injury sustained in the fall.

CIRCUMSTANCES OF THE DEATH

At the time of his death Mr ELLIOTT was in hospital for investigation / treatment of an underlying cardiac condition. His underlying cardiac condition was treatable, but he suffered a fatal brain injury when he had an inpatient fall.

Mr ELLIOTT had been admitted to Southmead Hospital on 29 August 2021.

On 31 August 2021, while he was on the Acute Medical Unit, Mr ELLIOTT's falls risk was assessed by a member of the nursing staff, who completed online documentation using the Trust's "Lorenzo" system.

That online documentation included a list of risk factors that had to be considered, the very first of which was whether the patient was aged 65 or over.

To reiterate, Mr ELLIOTT was 81 years old at the time (a fact that was recorded on the Lorenzo system).

The nurse recorded that Mr ELLIOTT had no risk factors (in respect of his risk of falls), despite his age.

The risk assessment was not only in error, but the error was obvious (and on an objectively verifiable basis – not simply on a subjective assessment of how the patient presented).

On 1 September 2021 Mr ELLIOTT was transferred to Cardiology ward 27a. In the early hours of 4 September 2021 he fell while trying to use the en-suite bathroom in his room, suffering a serious head injury which ultimately proved fatal.

There was uncontentious evidence that Mr ELLIOTT's underlying cardiac condition was treatable, and that if not for his fall (and head injury), he would have survived the inpatient admission and could have received treatment for his heart while in the community.

Mr ELLIOTT's brain injury led to a deterioration in his condition on 7 September, and he sadly died on 9 September 2021.

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. –

My concerns are about the quality (or otherwise) of the Patient Safety Investigation ("PSI") which took place after Mr ELLIOTT's death.

In Mr ELLIOTT's case the investigation (and accompanying report) overlooked obvious failings in his care. As a result important learning opportunities (and therefore important opportunities to improve patient safety in the future) were also missed.

I am concerned that if this investigation (and report) is in any way representative of the quality and rigour of such investigations within the Trust, then the Trust may be missing vital opportunities to learn from its mistakes, and to make its patients (now and in the future) safer as a result of that learning.

To give a little more detail:

- The stated remit of the Patient Safety Investigation was to "*review the care episode… [and] to understand the events and identify opportunities to learn and to improve patient safety*" (see page 4 of the resulting report)
- Given that this was a case where a patient suffered a fatal injury as the result of an inpatient fall, one of the first and most obvious points to investigate would have been the adequacy (or otherwise) of his falls risk assessment/s, and the extent of the nursing staff's compliance with any relevant Trust protocols / procedures
- Notwithstanding that background, the PSI report failed to identify the (very obvious) fact that although a falls risk assessment had been performed, it had not been performed properly
- There were also numerous *other* failings in the approach that had been taken to the assessment of Mr ELLIOT's falls risk, and/or the way that risk had been managed while he was an inpatient, but none of these were identified by the PSI / present in the report.
- For example:
  - Para.6.13 of the Trust's then-current Falls Prevention Policy stipulates that Mr ELLIOTT's family should have been made aware of the outcome of his falls risk assessment. That did not happen, but the fact that it did not happen is not mentioned in the PSI report.
  - There is no indication that Mr ELLIOTT's falls risk was ever re-assessed (after 30 August 2021). According to the Trust's policy it should have been reassessed after he moved to the Cardiology ward, and again after his fall on 4 September, but no such reassessment took place, and the PSI report makes no mention of these oversights/omissions.
  - *After* Mr ELLIOTT's fall on 4 September, he continues to be described as at "low risk" of falls in the Daily Intentional Rounding documentation within his medical records. This is an alarming error, but one which has been overlooked entirely by the PSI report.

- I asked Nurse ████ (one of the PSI-report authors, who gave evidence at the inquest) about the fact that none of these errors had been identified in the report and she had no explanation for why that was the case.

As stated above, if PSI reports overlook clear / obvious failings, then learning opportunities are missed, patient safety is compromised, and there is a risk of future deaths.

6. Deceased name: Ami Louise Mitchell

Date of report: 3rd November 2022
Report sent to: Avon & Wiltshire Mental Health NHS Trust.
Report by: Simon Fox

INVESTIGATION and INQUEST

On 22/06/2022 an investigation was commenced into the death of Ami Louise Mitchell. The investigation concluded at the end of the inquest on 3rd November 2022. The conclusion of the inquest was Suicide.

CIRCUMSTANCES OF THE DEATH

See below

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. –

Ms. Mitchell was under the care of AWP Trust with suicidal ideation from March to May 2022 until she hung herself on 31st May 2022.

Throughout this period she presented regularly and persistently with
a) delusions;
b) auditory hallucinations (including command);
c) visual hallucinations;
d) intrusive thoughts of killing her partner and children;
e) her and her family requesting admission
Despite this
a) No formal diagnosis was made;
b) No escalation in management or admission took place.

7. Deceased name: Celia Lindsey Marsh
Date of report: 21st November 2022
Report sent to: Food Standards Agency, UK Health Security Agency, Department of Health and Social Care, Dr XXXX, Dr XXXX, Royal College of Pathologists, British Society for Allergy and Clinical Immunology, British Retail Consortium, Food and Drink Federation, British Hospitality.
Report by: Maria Voisin

INVESTIGATION and INQUEST

On 17/01/2018 I commenced an investigation into the death of Celia Lindsey MARSH. The investigation concluded at the end of the inquest on 22nd September 2022.

The medical cause of death was found by me to be: 1a) Anaphylaxis triggered by the consumption of milk protein.

Based on the evidence I considered that the appropriate wording for Section 3 of the Record of Inquest form answering the questions "How, when and where the deceased came by her death should be as follows:

Celia Marsh died on 27th December 2017 at Royal United Hospital, Bath. She had a known allergy to milk. On that day whilst in Bath City Centre she ate a super veg rainbow flatbread which she believed was safe to eat; she suffered an anaphylaxis reaction caused by milk protein which was in an
ingredient within the wrap; this caused her to collapse and despite the efforts of the medical teams involved she died.

The conclusion of the inquest was a narrative which read as follows:

Celia was allergic to milk, she suffered anaphylaxis caused by the consumption of a wrap; the wrap was contaminated with milk protein. Celia was not aware that the wrap contained milk protein. The wrap contained a product which was marked as "dairy free coconut yogurt alternative", but despite this it contained milk protein, which was the cause of Celia's anaphylaxis. A product which is marked "dairy-free" should be, free from dairy. The contamination arose because an ingredient in the yogurt called HG1 had become cross-contaminated with milk protein during its manufacture. The manufacturer of the dairy free yogurt had in its possession documents which flagged this risk but this risk was not passed on to its customers.

CIRCUMSTANCES OF THE DEATH

Celia had known adult-onset allergy to cow's milk protein. On 27th December 2017 she was shopping with her family in Bath City Centre. She purchased a wrap from Pret a Manger and it appears likely that she had been reassured that the wrap was dairy-free. After eating the wrap, she suffered a severe anaphylaxis reaction to the milk protein in the wrap and died.

An investigation by the Bath and North East Somerset Trading Standards and indeed others traced the dairy to a product in the wrap which was made by Planet Coconut and marketed as a dairy free coconut yogurt alternative.

It was also found that the ingredient in the dairy free yogurt that caused the contamination was called HG1.

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. –

I indicated that my report would cover a number of areas to highlight the suggestions made by Dr XXXX Dr XXXX, Professor XXXX and others during the inquest. I explained that a report is not to dictate what that action should be however in this case I considered that it was right that I should pass on to those organisations suggestions made by the experts and indeed others who have assisted me in my investigation, it is of course a matter for you what if any steps you take.

The MATTERS OF CONCERN were as follows:

Concerns were raised in relation to the immediate investigation into a suspected death from anaphylaxis, that the evidence obtained at this time, with the right approach, can be invaluable to preventing deaths, but that to achieve this changes are required. This would need changes in the death investigation process and the wider investigation which would need assistance from the Food Standards Agency (FSA).

I was made aware that there needs to be better education both to doctors and to patients in risk groups to prevent future deaths

I was also advised that whereas the FSA would be required to assist with the above areas it could also assist in relation to the current practices of food labelling.

Firstly in relation to Pathology, I am told that the current guidance is 10 years old, the suggestion is for this to be revisited and specifically:

- If bloods are taken at hospital that they are not destroyed in a suspected case but retained for testing
- That an early blood sample is taken after death and stored for late analysis
- That the possibility that a death is due to anaphylaxis is raised with the Senior Coroner for the area where the death occurred at the earliest opportunity
- That an early blood sample is taken after death
- The post mortem examination should be prioritised.
- At the post mortem examination: that stomach contents are taken and frozen to enable testing and that tissue samples are taken

A standard protocol should be available to ensure appropriate samples are taken at the correct time to assist later investigation.

In relation to doctors/patients:

- To highlight, through public awareness and to the medical profession, that while the majority of food-allergic individuals are at very low risk of fatal reactions, a small subset of food-allergic individuals may be at significantly higher risk. These persons must be given appropriate advice as to the dangers of inadvertent exposure, since there may be no detectable safe level of allergen that can be present in a product for this group.
- To be aware that avoidance of foods in adults does not improve eczema and may result in more severe allergy to the food avoided particularly to cow's milk but tolerance can be maintained by continued regular exposure.

In relation to the FSA, the UK Health Security Agency and the Department of Health and Social Care:

- To establish a robust system of capturing and recording cases of anaphylaxis, and specifically, fatal and near-fatal anaphylaxis, to provide an early warning of the risk posed to allergic individual by products with undeclared allergen content.
- Such a system could involve *mandatory* reporting of anaphylaxis presenting to hospitals, analogous to the current system used for notifiable diseases (including some food-borne illnesses) whereby registered medical practitioners have a statutory duty to notify the 'proper officer' at their local council or local health protection team of suspected cases of certain infectious diseases. An example of such a reporting system for anaphylaxis already exists in the state of Victoria in Australia, and also allows for rapid alerts of serious cases to public health authorities to expedite investigation and evaluate the public health risk.

In relation to the FSA, the British Retail Consortium, Food and Drink Federation and British Hospitality:

- The wording used on food products, and the public's understanding of these phrases in terms of implying the absence of a particular allergen, can be potentially misleading. Examples include: "free-from" and "vegan". Foods labelled in this way must be free from that allergen, and there should be a robust system to confirm the absence of the relevant allergen in all ingredients and during production when making such a claim.
- With respect to those with the most severe food allergies, it may be necessary in the interim to clarify that foods labelled "free-from [X allergen]" may not be safe to consume.

In relation to the FSA:

- A hotline to the FSA to provide guidance in fatal cases due to suspected anaphylaxis, although a mandatory reporting system (suggested above) would address this need.
- Nationally recognised best practice and technical advice to assist those investigating such cases;