Maria Eileen Voisin

HM Senior Coroner for the Area of Avon

Annual Report

2018/2019

"...It is the duty of the coroner as the public official responsible for the conduct of inquests … to ensure that the relevant facts are fully, fairly and fearlessly investigated … He must ensure that the relevant facts are exposed to public scrutiny, particularly if there is evidence of foul play, abuse or inhumanity. He fails in his duty if his investigation is superficial, slipshod or perfunctory. But the responsibility is his. He must set the bounds of the inquiry. He must rule on the procedure to be followed. His decisions, like those of any other judicial officer, must be respected unless and until they are varied or overruled…"

R. v North Humberside and Scunthorpe Coroner, ex p. Jamieson [1995] QB 1

Contents

1. *Introduction*

This is the first annual report of the Senior Coroner for the Area of Avon. This report provides a brief overview of the role of the coroner and the importance of the role as an independent judicial officer. It describes the geographical area and complexity of the jurisdiction, and the challenges to the coroner's service as a consequence.

The report will highlight some previous key achievements and challenges, as well as proposed future developments which will affect the service throughout the jurisdiction.

The important role of a coroner includes making recommendations to appropriate organisations in order to prevent future deaths. This report includes details of the recommendations made during 2018.

The report considers the statistics on the activity of coroners' areas nationally and how the Area of Avon compares to the national picture.

2. *Role of the Coroner*

It is the role of the coroner to investigate, and if necessary to conduct an inquest, if the coroner has reason to suspect that the deceased died a violent or unnatural death; where the cause of death is unknown; or where the person died in custody or state detention.

The coroner may request a post mortem examination, where it is considered necessary, to enable the coroner to decide whether the death is one where an investigation is required. A post mortem examination will be ordered if, for example, a registered medical practitioner is unable to give an opinion as to the medical cause of death.

An inquest is not to determine matters of civil or criminal liability, nor to seek to apportion blame for the death. The purpose is simply to answer four questions:

Who is the person that has died?
Where did they die?
When did they die?
How did they die?

"How" in coronial terms means "by what means" and this is extended only for those inquests where it is arguable that there has been a breach of Article 2 of the European Convention on Human Rights, to "how and in what circumstances".

3. ***The Importance of Independence***

The coroner is an independent judicial officer, responsible to the Crown, who can only be removed from office by the Lord Chancellor with the agreement of the Lord Chief Justice for incapacity or misconduct. The local authority appoints the coroner but they do not employ them, and this is an important distinction to maintain independence.

The autonomy of the office is an important safeguard for society and a key element in the investigation of death.

Nonetheless, coroners cannot operate in a vacuum and need resources and administrative support from local government as well as manpower and the investigative abilities of the police.

4. ***The Area of Avon***

The coroner's Area of Avon was set up under The Avon (Coroners) Order 1996 which covers the counties of Bristol (as the lead authority), South Gloucestershire, Bath and North East Somerset, and North Somerset. All four unitary authorities contribute to the budget and therefore support the office of coroner locally.

The Area of Avon is very diverse, covering a large geographical area incorporating the cities and towns of Bristol, Bath and Weston-super-Mare, with a population estimated at over 1.1 million. It has an extensive coastline with rural and industrial areas. It has an international airport. There are four prisons, namely: Leyhill, Eastwood Park, Bristol and Ashfield. There is a large motorway network with a large interchange. Avon has a number of regional hospitals and mental health units including Southmead Hospital, Bristol Royal Infirmary, Bristol Royal Hospital for Children, Royal United Hospital Bath, Weston General Hospital, Callington Road Hospital. Together all of these result in the Avon area having a significant number of complex and high profile inquest cases.

5. Key Achievements and Challenges in 2018/2019

- Avon, together with Bristol City Council and the office of the Chief Coroner, with the assistance of Mr Tom Osborne, HM Senior Coroner for Milton Keynes, recently appointed Avon's first Area Coroner. This post is a 0.8 full time post which will greatly assist in the running of the service. Thank you to all of those involved, and welcome to this new post Dr Harrowing.

  This has created a team of 4 assistant coroners and an area coroner now supporting the senior coroner in her work.

- The Chief Coroner provides national guidance to coroners and it is the responsibility of the senior coroner to consider and make appropriate changes locally to adopt this guidance. In recent years there has been significant guidance issued which assists in ensuring that there is greater consistency nationally. Some examples of the more recent guidance includes: General Data Protection Regulation (GDPR), judge-led inquests, juries, transfer of investigations to another coronial area, and documentary ('read only') inquests.

- The senior coroner is a member of the Council of the Coroners' Society for England and Wales and attends regular meetings to ensure that developments and changes nationally are known and acted upon. This ensures that changes can be made locally and adaptions to the local service made to maintain best practice. It is the view of the senior coroner that it is of the utmost importance to ensure that the local service is aligning itself to what is expected and strived for nationally.

- There has been a reduction in the number of deaths reported due to natural causes in Avon. This is in part attributed to the senior coroner's work with Brisdoc, the out of hours GP service, to set up a process which no longer requires cases being referred to the coroner where the death is due to natural causes. This service has had a number of additional benefits, the most significant impact is that it enables families to proceed with the usual funeral arrangements without the involvement of the police or coroner. Another benefit is a reduction in the need for police officers to attend a death due to natural causes where the death is essentially not unexpected. Due to the success of this process, Avon and Somerset police are working with the senior coroner and Mr Tony Williams, HM Senior Coroner for Somerset, to roll out the practice in Somerset.

- Nationally and locally there is an ongoing concern about the shortage of available pathologists to carry out post mortem examinations. Locally, pathologists based at the Royal United Hospital, Bath withdrew from providing a post mortem service to the coroner at the end of 2018. This has resulted in an increase to the workload of the mortuary at Flax Bourton.

As a result of the shortage of pathologists, there can be a delay in the post-mortem examination being performed. This adversely affects the coroner's ability to make a decision as to whether, or when, to start an investigation or inquest. However, and most importantly, it delays the release of the body for the funeral and therefore this impacts significantly on families.

The Chief Coroner's proposal is for 12- 15 regional centres of excellence providing mortuary, post mortem examination and post mortem imaging (CT scanning) facilities.

- The reported cases are all managed via a case management system (Civica™) which went live in February 2018. The system is bespoke to the processes set up in Avon and it has assisted in ensuring that cases are managed in a timely manner.
- The Avon coroner's website www.avon-coroner.com continues to provide the public and press with details of all hearings, which is updated weekly. It is also a source of information which includes how to contact the office, a guide to the inquest process, and links to other useful websites such as the gov.uk site which explains how to register a death.
- Wifi has been installed throughout the court building which allows those visiting the court to access the internet and importantly enabling advocates to respond urgently to matters as they may arise during an inquest.
- The archiving, retrieval and destruction of paper files has also been streamlined through the use of the Modern Records Unit of Bristol City Council, enabling efficient and secure document management.
- GDPR brought some challenges but processes and systems have been put in place to ensure that the coroner's service is operated in line with GDPR. It should be noted that there are many coroners who consider that GDPR does not apply to the work they do and that is correct to an extent, but the senior coroner has taken the view that the service should make changes to ensure there is compliance in appropriate circumstances.
- Senior coroner involvement in improved disaster victim identification contingency planning.

6. ***Coroner Statistics 2018***

The statistics for Avon for the years 2006 – 2018 as compared against the national picture appear in Annex A.

It should be noted that comparing coroner areas is fraught with difficulties, since areas are set up differently with different levels of staffing and support from their local authorities. Geographically the areas are widely different: some areas do not cover major cities, while others may or may not have prisons or large regional hospitals within them. It is with this caveat and in this context that you should consider the statistics.

Coroner's statistics are produced by the Ministry of Justice annually with the Office for National Statistics (ONS), and for 2018 they were produced on 9th May 2019. They are available to review for the whole of England and Wales on the website:

https://www.gov.uk/government/statistics/coroners-statistics-2018

In addition the Chief Coroner, His Honour Judge Mark Lucraft QC, has produced his fifth annual report for the period 2017-2018. This report is also available to review at:

https://www.gov.uk/government/publications/chief-coroners-annual-report-2017-to-2018

At the time of these reports, there were 88 coroner areas. In 2013 there were 110 coroner areas. Current planning by the Ministry of Justice is to reduce the number of coroner areas to 75 in the long term. The reasons for this reduction are to establish coroner's areas of similar size, achieve greater consistency, as well as seeking to achieve benefits in terms of cost savings.

Avon is now the 9th largest area with 4,027 deaths reported in 2018, the largest being Essex with 6,914.

In 2018 the average time to complete the process (from the time the death was reported to the inquest being concluded) in Avon was 17 weeks, compared to the average of 26 weeks for England and Wales over the same period. There has been a sustained reduction in the time taken in Avon since 2010 when this period was 38 weeks.

Post mortem examinations conducted as a percentage of the number of deaths reported in Avon was 36% with the average (mean) for England and Wales being 39%. By way of comparison, the percentage of post mortem examinations conducted in Avon in 2010 was 44%.

In 2018 the number of inquest conclusions in Avon was 845, of which 9 were jury inquests taking up 16.2 weeks of court time.

The Chief Coroner's report also details the number of cases for 2018 which have not been concluded within 12 months. These figures include those cases where there is an ongoing

police investigation, criminal case or prosecution; investigations overseas; Health and Safety Executive or Prison and Probation Ombudsman inquiries; investigations by the Independent Office for Police Conduct (IOPC); and investigations by the accident investigation bodies such as the Air Accidents Investigation Branch.

In summary, these cases include those which are being investigated or prosecuted by an external authority or where the death is abroad and therefore another country is investigating the death. In such cases the timescales are governed by other organisations or foreign jurisdictions and the coroner has very little, or no control over the timescales for the investigation. Therefore this results in the coroner's investigation being put on hold pending the outcome of those other investigations which are often lengthy.

In 2018 Avon had 12 such cases over 12 months old, which were made up as follows:

- Deaths abroad = 3
- Investigation or prosecution by external authority = 6
- Complex case = 2
- Prepared for inquest and listed = 1

Again care should be taken when comparing statistics with the numbers nationally varying considerably with 2 coroners in 2018 having over 100 cases over 12 months old.

7. 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 2018 are detailed in Annex B

8. Future Developments:

This year will no doubt continue to bring some challenges and changes which will include:

- An appraisal scheme for assistant coroners is being rolled out nationally and will be adopted locally. The aim of the scheme is to improve consistency both locally and nationally, and to ensure that any training needs are identified and actioned.
- There is to be a phased introduction of the national medical examiners' system from April 2019 which will assist in ensuring more appropriate referrals of deaths to coroners. Locally the medical examiner system has yet to be introduced. However, there have been a number of meetings with the senior coroner and the process to set this up has begun. The medical examiner system will initially only cover hospital deaths, with deaths in the community to be included at a later date.
- It is anticipated that the Civica™ system will be set up to allow for professional referrals through an online portal, which will save time for the coroner's officers when inputting the case details.
- The court audio/recording system is to be replaced in August 2019 which will allow for video links to the court for witnesses to give their evidence remotely and improve the quality of recordings. It is also expected that this will improve the hearing loop in the court for those that are hearing impaired.

9. Acknowledgements

The staff at the coroner's office work as one team but are employed by both Bristol City Council and Avon and Somerset Constabulary. They all work incredibly hard and diligently to ensure that standards are maintained and all deaths are investigated and handled in a professional and expeditious way.

The senior coroner would like to take this opportunity to thank the teams for their continued commitment, hard work and support.

The senior coroner would also like to acknowledge the work of the area and assistant coroners within the team, all of whom are committed to their public role when sitting in court as well as undertaking other duties. They demonstrate their judicial impartiality and professionalism to the highest standards.

Finally, particular thanks must also go to the Coroner's Court Support Service, the team of volunteers who offer support to bereaved families and other witnesses when attending court.

Maria Eileen Voisin

HM Senior Coroner

Annex A: Statistics from 2006 – 2018

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

Annex B: Reports to Prevent Future Death 2018 (redacted copies)

1.
Deceased name: John Frederick Wherlock
Date of report: 28th March 2018
Report sent to: University Hospitals Bristol NHS Trust
Report by: Robert Sowersby, Assistant Coroner

"On 30th May 2017 an investigation into the death of John Frederick Wherlock, aged 90 years, was commenced. The investigation concluded at the end of the inquest on 23rd February 2018. The conclusion of the inquest was as follows:

The medical cause of death was recorded as
1a) Gastrointestinal bleed
2) Hip fractures (operated), frailty, chronic kidney disease

The narrative conclusion was recorded as:

Mr Wherlock already had a fractured hip and was at a high risk of further falls. He was left unsupervised and fell again, suffering a second fracture. Sadly his condition deteriorated and he died in Bristol Royal Infirmary on 23 May 2017.

The deceased was an inpatient on Ward 518 at the BRI. He was elderly and confused, had already suffered a fractured hip in one fall, and was at a high risk of further falls. He was left unsupervised and during that time tried to get out of bed: he fell again, fracturing his hip on the other side, and that fracture contributed to his subsequent death.
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: –

(1) I was told in evidence that at the time of the accident the ward was being covered by two nurses and two nursing assistants (ie, by 4 staff), but that two of those staff had taken their 1-hour break at the same time; effectively leaving the ward with very little cover. The fall had then occurred when a nursing assistant left the deceased's bay to help another member of staff to change a bed (leaving him entirely unsupervised).

(2) While I would be concerned in any event that staff had taken their breaks at the same time – given the effect that that would inevitably have on the remaining nurses' ability to cope with the patients on the ward – I was even more concerned when the nursing assistant who gave live evidence at the inquest told me that this was a practice which was still taking place; despite it having been highlighted and criticised in the serious untoward incident report."

2.
Deceased name: Sandra Miller
Date of report: 25th January 2018
Report sent to: Milestones Trust
Report by: Dr Peter Harrowing, Assistant Coroner

"On 27th June 2016 I commenced an investigation into the death of Ms Sandra Miller age 55 years. The investigation concluded at the end of the inquest on 24th January 2018. The conclusion was that the medical cause of death was:
I a) Pneumonia; II E. coli septicaemia due to a urinary tract infection. Heart failure.
The conclusion as to the death was: The Deceased died of pneumonia contributed to by heart failure and E. coli septicaemia consequent upon a urinary tract infection.

The deceased suffered with Down's syndrome, Alzheimer's disease, hypothyroidism, type II diabetes mellitus and she had an epigastric hernia. She had impaired swallowing and on occasion suffered with aspiration pneumonia.

In May 2015 she was discharged from hospital to reside at Mortimer House Nursing Home, Bristol, which is owned and managed by the Milestone Trust. On discharge from hospital she had a urinary catheter due to a voiding dysfunction. This voiding dysfunction was considered to be related to her neurological condition. She was also incontinent of faeces. At a Best Interests Meeting held on 20th August 2015 it was determined that owing to Ms Miller becoming distressed and agitated at the time when her urinary catheter was changed it was agreed that she could be sedated for this procedure. Removal of the catheter was considered but when removed on previous occasions she had gone into urinary retention. Therefore it was planned to refer her to the urologist for further advice.

She was seen on 15th September 2015 by [redacted] Consultant Urological Surgeon. Ms Miller would become agitated and try to remove or pull at the urine bag. As a result it had become practice at Mortimer House to remove the bag and tubing and allow the open catheter to drain freely on to a pad. In his letter of 30th September 2015 to the GP and copied to Mortimer House [redacted] noted that this practice meant that there was an open system from the outside world to the bladder which would increase her risk of infections and that this practice should not be continued. He recommended the use of a flip-flow valve if a bag could not be used and if that was not successful to consider a suprapubic catheter. The GP in evidence stated that the GP records indicate the advice given to the staff at the home was to try the flip-flow valve.

A copy of this letter was date stamped as being received at Mortimer House on 15th October 2015. However, in evidence the Assistant Home Manager stated that letter had not been seen by her or her colleagues and therefore the recommendations of [redacted] were not acted upon. Consequently the practice of leaving the urinary catheter on free drainage continued.

In evidence the Assistant Home Manager further stated that Ms Miller, who was incontinent of faeces, wore incontinence pads, and the open end of the catheter was 'tucked inside' this

incontinent pad and the pad changed four times daily. Therefore the open end of the catheter was in contact with, or close to, any faeces.

On 15th June 2016 Ms Miller became unwell and she was attended urgently by an Emergency Care Practitioner from the out-of-hours GP service. He assessed her as suffering with sepsis probably due to pneumonia or possibly a urinary tract infection. Ms Miller was admitted as an emergency by ambulance to Southmead Hospital, Bristol.

The Staff Nurse in the Emergency Department observed the catheter to not be connected to a bag nor was a spigot fitted. In evidence the Staff Nurse stated the tip of the catheter was dirty. On removing the catheter a large quantity of foul smelling, pus-like urine drained from the bladder suggesting the catheter had been blocked.

Investigations revealed she was suffering with a respiratory and / or a urinary tract infection and heart failure. She was treated for sepsis and blood cultures later revealed she had an E.coli septicaemia.

Notwithstanding appropriate antibiotic therapy Ms Miller's condition declined and she died in hospital on 21st June 2016. The primary cause of her death was considered to be pneumonia.

At the inquest the Area Manager of Milestones Trust, a registered nurse, who conducted a review in advance of the Inquest could not confirm that action had been taken to stop this practice of leaving a urinary catheter to free drainage, that proper procedures had been implemented, and that staff had received any necessary training.

The MATTERS OF CONCERN are as follows. –

(1) Urgent action must be taken to ensure the practice of allowing open ended urinary catheters to drain freely is stopped in all homes and facilities under the management and control of Milestones Trust.
(2) Proper procedures must introduced with regard to the safe care and management of urinary catheters with the assistance of specialist advice if necessary.

All relevant staff must be properly trained in the care and management of urinary catheters."

3.
Deceased name: John Philip ASHWIN
Date of Report: 18th April 2018
Report sent to: Virgin Care
Report by: Dr Simon Fox, Assistant Coroner
"On 19/07/2017 an investigation was commenced into the death of John Philip ASHWIN. The investigation concluded at the end of the inquest on 18th April 2018.

The medical cause of death was given as:

1a) Pulmonary thromboembolism
1b) Deep venous thrombosis
2) Immobility related to lumbar spinal fracture and urinary tract infection. Ischaemic heart disease.

The conclusion of the inquest was accidental death.
Mr Ashwin died in hospital after a short illness following a fall.

The MATTERS OF CONCERN are as follows. –

(1) Deceased developed pressure sores on left heel and sacrum by 26.5.17, within 8 days of admission
(2) A Waterlow Risk Assessment that day by a Healthcare Assistant was not completed correctly
(3) The Deputy Ward Sister noted the pressure sores but did not
    i) complete a waterlow score assessment
    ii) assess or put in place any action to manage the pressure sores.
(4) The same Deputy Ward Sister is partly responsible for training more junior nursing staff in correct assessment, documentation and management of pressure sores"

4.
Deceased name: Yazin Elhjaje
Date of Report: 26th April 2018
Report sent to: Universities Bristol NHS Trust
Report by: Maria Voisin, Senior Coroner
"On 18/10/2017 I commenced an investigation into the death of Yazin ELHJAJE. The investigation concluded at the end of the inquest 26th April 2018.

The conclusion of the inquest was a narrative which read as follows:
Yazin died from bacterial meningitis which was diagnosed on 7th October 2017. He had been unwell for about a week with a headache but since 5th October developed a fever. On 7th October at 2am he was seen at the hospital examined and discharged, he did not have a full set of observations and his discharge letter stated that meningitis had not been completely ruled out. He was discharged at 2.45 am and his condition over the day deteriorated. He was taken by ambulance to the hospital at around 5pm on 7th October 2017 but died on 8th despite the treatment provided at that time.

Yazin Elhjaje became ill on 6th October 2017 and was taken to see his general practitioner, she was concerned about his presentation and that it could be meningitis, he was managed at home and then taken to hospital later that day with a letter from the general practitioner raising her concern. Yazin was examined and discharged with a diagnosis of sinusitis. His condition deteriorated over the next few hours and he was taken back to the hospital by ambulance, by now he was very ill, it was confirmed that he probably had meningitis, his condition deteriorated despite the treatment and he died on 8th October 2017 at Bristol Royal Hospital for Children Upper Maudlin Street Bristol

The MATTERS OF CONCERN are as follows. –

I heard during the inquest that the safety-netting advice on discharge given to Yazin's parents was in relation to his headaches and not in relation to the differential diagnosis of meningitis.

I would ask that consideration is given to the safety-netting advice provided to parents in cases where meningitis has been considered as part of the differential diagnosis as in this case."

5.
Deceased name: Michalla Jane SWEETING
Date of Report: 21st May 2018
Report sent to: Bristol Community Health
Report by: Maria Voisin, Senior Coroner

"On 13/07/2016 I commenced an investigation into the death of Michalla Jane SWEETING. The investigation concluded at the end of the inquest.

The medical cause of death was:

1a) Aspiration of gastric content in association with methadone toxicity

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

"Michalla's death was contributed to by inadequate carrying out and response to prison officer ACCT checks, unsatisfactory handover quality between shifts, inappropriate process of assessment at the medicine dispense hatch and inadequate communication between healthcare and prison staff.
There was neglect due to a combination of the following gross failures:

- Nurse to act on handover by HCA as noted on system one 1st June 2016 at 14.50 by physically assessing Michalla and making a plan and by still administering Methadone at 17.56
- Nurse failed to check and update Michalla's records and contact a doctor and formulate a care plan after witnessing Michalla being sick at 22.14 1st June 2016
- Nurse performed woefully inadequate clinical observations from 1st June 2016 at 22.14 onwards, including 2nd June 2016 at 03.21"

Deceased was a remand prisoner. She was undergoing a detoxification programme and was on an ACCT. There were concerns raised by a number of people including a healthcare assistant that she was over sedated and this was reported to 2 nurses, Michalla was not physically assessed and she was still given her Methadone after this concern was raised.

It appears unlikely that Michalla's over sedated appearance was handed over from the day to the night clinical staff.

Later that day she was seen by Nurse [redacted] who saw Michalla unwell in her cell, he did not check her records which included a reference to her being over sedated that day; he did not put his entry in the records until after Michalla's death; he did not carry out observations or make a plan and the one observation he did carry out at 03.21hrs on 2nd June 2016 was described as woefully inadequate by the expert.

Sadly Michalla was found unresponsive in her cell at 07.00hrs on 2nd June 2016.
Her cause of death is described above

The MATTERS OF CONCERN are as follows. –
For Bristol Community Health:

1. Handover:
    a. That the handover includes all prisoners/patients undergoing detoxification.
    b. That the handover is the responsibility of the registered nurse
    c. That it includes a review of the records for the shift by that registered nurse – this was raised by Professor [redacted] and was reflected in the jury conclusion. I therefore report this to you for your consideration in preventing future deaths

2. Observations for prisoners/patients undergoing detoxification: that they are taken at a time which is close to the time of dispensing medications so that the staff administering the medication have that information. Again this was raised by Prof [redacted] as being the best time to review the observations and was indeed reflected in the jury conclusion. "

6.
Deceased name: Graham William FOX
Date of Report: 8th June 2018
Report sent to: University Hospitals Bristol NHS Trust
Report by: Robert Sowersby, Assistant Coroner

"On 12th July 2017 an investigation commenced into the death of Graham William FOX. The investigation concluded at the end of the inquest on 8 June 2018. The conclusion of the inquest was that he died of (Ia) chronic obstructive pulmonary disease and pneumonia, and (II) left hip fracture (operated) and ankle fractures.

My narrative conclusion included the following:

His condition deteriorated, and overnight from 25 June hospital staff did not correctly implement the standardised method of assessment and referral ['NEWS'] that was in use at the time, which meant that he was not seen by a doctor as he should have been, and the seriousness of his condition was not recognised until 26 June, when he was admitted to the Critical Care Unit in which he subsequently died.

Mr Fox had a history of alcohol misuse and had had a fall in the community in which he broke both ankles. He was admitted to hospital and was being monitored using the NEWS system. He had been "re-triggered" by the hospital's doctors, so that although normally an oxygen saturation, or a blood pressure reading, below a certain level would add points to the NEWS total, in Mr Fox's case points would not be added unless his score dipped below the new revised ("re-triggered") level.

Mr Fox's 'normal' NEWS was 5, after which he was reviewed, "re-triggered", and when later assessed his score was 5 again (using the new re-triggered means of NEWS assessment). That represented a real-world deterioration in his condition, but because the number itself did not go up, the nursing staff were relatively unconcerned. The NEWS of 5 was in due course relayed to the on-call doctor, but the doctor did not attend, even though she was on the same ward seeing another patient that evening.

Mr Fox then had a series of inadequate observations taken overnight (which were not sufficient to enable any calculation of his NEWS total). By the time his NEWS total was properly calculated in the morning it was 9: he was then admitted to the Critical Care Unit, where his condition deteriorated and he sadly died.

The MATTERS OF CONCERN are as follows. –

(1) The standard NEWS documentation contains a list of scores on the left, and corresponding clinical responses in a column on the right. My understanding of the system was that when the relevant score was reached, the corresponding clinical response was mandatory. The impression I gained from listening to the majority of the nursing staff was that there was an element of discretion / clinical judgment to be applied in determining whether the clinical responses that were 'required' when the relevant score was reached were actually necessary. The more senior nursing

staff were clear that the relevant responses were mandatory, but that was not the impression given by the more junior staff. This evidence (which gave the impression that staff discretion could be applied to the clinical responses) was given after the staff had, apparently, been given additional NEWS training following Mr Fox's death.

(2) I did not have the benefit of any expert evidence about the process of "re-triggering" patients under NEWS, and I am therefore unable to comment on whether it is clinically appropriate. I did hear evidence that the practice was commonplace within the hospital."

7.
Deceased name: Jacqueline Dympna JORDAN
Date of Report: 24th August 2018
Report sent to: Bristol City Council
Report by: Maria Voisin, Senior Coroner

"On 14/12/2017 I commenced an investigation into the death of Jacqueline Dympna JORDAN. The investigation concluded at the end of the inquest. The conclusion of the inquest was: Road Traffic Collision

Mrs Jordan died on 18th November 2017 at Passage Road, Brentry, Bristol. At around 6pm she had walked across the dual carriageway and central reservation which was a shortcut known to be used by pedestrians but which was not a designated crossing. She was struck by a car as she stepped into the path of the car, she was pronounced dead at the scene.

The MATTERS OF CONCERN are as follows:

I was told by the police officer and the family that a barrier exists throughout part of the central reservation along this dual carriageway but is absent throughout this short stretch. If there was a barrier throughout this central reservation then it would potentially deter certain members of the public using this shortcut. I was told that there are 2 pedestrian crossings nearby "

8.
Deceased name: Henry Jack MILLER
Date of Report: 29th August 2018
Report sent to: Foreign & Commonwealth Office
Report by: Maria Voisin, Senior Coroner

"On 28/05/2014 I commenced an investigation into the death of Henry Jack MILLER. The investigation concluded at the end of the inquest. The conclusion of the inquest was: Accident

Henry Miller died on 23rd April 2014 at Vereda El Aguacate, Mocoa, Putumayo, Columbia. He died as a result of intoxication after consuming a psychoactive substance during a tribal ceremony. He was struggling to breathe after the ceremony and it was decided that he should be taken to hospital. On the way to the hospital he was left dead by the side of the road.

The MATTERS OF CONCERN are as follows. –

Many travellers go to this area of Columbia and some will consider participating in a tribal ceremony when Yage will be consumed. Many will check with the FCO about any issues or warnings about their travel plans. I would therefore ask you to consider whether a warning or advice should be issued to such travellers exploring this area of Columbia so that they can receive well informed guidance before traveling and deciding whether it is safe to participate in such a ceremony."

9.
Deceased name: Susan Longden
Date of Report: 18th December 2018
Report sent to: NHS Digital
Report by: Dr Peter Harrowing, Assistant Coroner

"On 26th February 2018 I opened an Inquest into the death of Mrs Susan Longden age 69 years. The inquest was heard 26th - 28th November 2018. The conclusion was that the medical cause of death was
I (a) Acute intra-abdominal haemorrhage; I (b) Splenic injury ascribed to recent colonic perforation during colonoscopy

The conclusion as to the death was: The Deceased died after suffering a very rare complication of a routine, but necessary, colonoscopy.

The circumstances leading up to Mrs Longden's death are that on the morning of 31st January 2018 Mrs Longden attended Weston General Hospital where she underwent a routine surveillance colonoscopy. This procedure was performed by a Nurse Endoscopist. She was discharged from hospital at around 12:00 hours approximately one hour after the procedure was completed.

During the early afternoon that same day Mr [redacted], telephoned the Endoscopy Unit and spoke to a staff nurse and reported that [redacted] was experiencing abdominal pain and requested some advice. The staff nurse advised she be given paracetamol tablets and a drink and she also spoke with Sister on the Endoscopy Unit who, in turn, telephoned [redacted] reported [redacted] pain scored 9/10. Mrs Longden had taken the paracetamol tablets and Sister telephoned [redacted] again approximately 45 minutes later at around 15:00 - 15:15 hours and was advised Mrs Longden's pain was now 8/10 and she was feeling slightly better. The Sister made a further telephone call at around 16:10 hours when the pain was scored at 6/10 and Mrs Longden reported feeling slightly better. At around 18:45 hours the Sister made a further call and Mrs Longden reported the pain was 5/10 and she was feeling better.

Mr [redacted] states that [redacted] went to bed at around 20:00 hours and shortly afterwards she started yelling out in pain. He telephoned NHS 111 (operated by Care UK) at 20:53 hours. The call was taken by a non-medical Health Advisor (1) who followed the NHS Pathways computerised triage tool. The Health Advisor was told that she could not speak to Mrs Longden and therefore all information was provided by Mr [redacted] At the conclusion of the telephone call the outcome generated was that a Category 3 ambulance was to be called. In accordance with the procedures of the NHS 111 service this required approval by a Clinical Advisor (a nurse). The call was passed to the Clinical Advisor who spoke with Mr [redacted] and arranged for a doctor to call within two hours rather than a category 3 ambulance.

A short while later at 21:41 hours Mrs Longden became unresponsive and after calling NHS 111 (operated by Care UK) again the Health Advisor (2) a Category 1 ambulance was called immediately and arrived at around 21:49 hours. The paramedics confirmed she was in

cardiac arrest. At 22:40 hours there was return of spontaneous circulation but she suffered a further cardiac arrest at 22:50 hours. Subsequently Mrs Longden was taken to the Emergency Department of the Bristol Royal Infirmary where she arrived at 00:05 hours (1st February 2018). She had had a prolonged period of cardiac arrest and this was deemed an unsurvivable event and she was pronounced deceased at 02:00 hours.

The MATTERS OF CONCERN are as follows. –

(1) The NHS Pathways algorithm does not include a question with regard to recent surgical or interventional procedures where a patient is reporting severe abdominal pain. The close association in time between such a procedure and the onset of symptoms may well be significant in ensuring prompt action is taken to investigate the cause of the symptoms.

(2) Where the caller to NHS 111 is not the patient then the Health Advisor continues to follow the algorithm by obtaining information from the caller and not the patient. There should be greater emphasis on trying to speak with the patient and the reason(s) why the patient cannot came to the telephone. The information provided by the patient themselves and the manner in which that information is provided may well affect the outcome of the triage process.

During the course of the inquest I heard evidence from Dr [redacted] the Medical Lead, SW111 Care UK, that concerns have been raised with your organisation on previous occasions. The case references provided by Dr [redacted] are P130273, P132849 and P133040"

10.
Deceased name: Annette Hill
Date of Report: 21st September 2018
Report sent to: Southmead Hospital
Report by: Terence Moore, Assistant Coroner

"On 18/07/18 I commenced an investigation into the death of Annette Hill. The investigation concluded at the end of the inquest 20th September 2018. The conclusion was the deceased was transported to the emergency department with increasing breathlessness. She was appropriately assessed under the trusts sepsis protocol and given antibiotics before a chest x-ray could be taken. She suffered an unexpected reaction and died despite advanced CPR. Presented to the emergency department with COPD collapsed following a dose of IV amoxicillin.

The MATTERS OF CONCERN are as follows:
This patient received IV antibiotics correctly and in accordance with the Sepsis 6 guidelines. However she did not in fact require antibiotics on an overview of the available information. There appears to be an unresolved tensions between the Sepsis 6 guideline and the BTS COPD care bundle for the management of patients with advanced respiratory disease."