Maria Eileen Voisin

HM Senior Coroner for the Area of Avon

Annual Report

2019/2020

"*...An inquest is a fact finding inquiry conducted by a coroner with or without a jury to establish reliable answers to four important but limited factual questions. The first of these relates to the identity of the deceased, the second to the place of his death, the third to the time of his death. In most cases these questions are not hard to answer, but in a minority of cases the answer may be problematical. The fourth question, and that to which evidence and inquiry are most closely directed, relates to how the deceased came by his death …*"

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

Contents

1. ***Introduction***

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

In this report I will summarise what the role of the coroner is and what the Avon jurisdictional area covers.

This report will review what progress has been made, with the developments put forward in the 2018/19 report. It will highlight other key achievements and challenges in 2019/2020, and it will take into account the pandemic in relation to the future recovery and plans.

The report generally covers the period from approximately April 2019 to March 2020. However due to the timing of when national statistics are produced the report considers those for 2019 (on the activity of coroners' areas nationally and how the Area of Avon compared to that national picture). Cases which are over 12 months old are not reported until the end of April each year so this report will cover the period 2016 to 2019.

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 2019.

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

A coroner is an independent judge who investigates deaths if they have reason to suspect that:

- The death was violent or unnatural; or
- The cause of death is unknown; or
- The deceased died while in state detention.

When a death is reported to the coroner they will make preliminary inquiries to decide if an investigation is required, if so investigate to establish the identity of the person who has died; how, when, and where they died; and any information required to register the death;

and may use information discovered during the investigation to assist in the prevention of other deaths.

The coroner may decide to hold an Inquest as part of the investigation. An inquest is a public court hearing held by the coroner to decide who died and how, when and where the death happened. It may be held with or without a jury, depending on the circumstances. At the inquest the coroner will hear from witnesses and consider other evidence such as post-mortem or expert reports.

An inquest is different from other types of court hearing because there is no prosecution or defence and only the coroner can decide what evidence to hear. As the purpose of the inquest is only to discover the facts of the death the coroner (or jury) cannot find anyone criminally responsible for the death. However, if evidence is found that suggests someone may be criminally responsible for the death, the coroner can pass the evidence to the police or the Crown Prosecution Service. Similarly, the coroner (or jury) cannot find someone liable under civil law. These are matters for other courts.

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

The coroner is an independent judicial officer, 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. It has an extensive coastline with rural and industrial areas. It has an international airport. There are four prisons. There is a large motorway network. Avon has a number of regional hospitals and mental health units. Together all of these result in the Avon area having a significant number of complex and high profile inquest cases.

5. Progress with the future developments in the 2018/2019 report?

- Appraisal scheme for assistant coroners – this was successfully rolled out in 2019 and was completed in early 2020. The reviews involved the senior coroner observing each assistant coroner in court to assess their skills and ability; an assessment of their administrative skills was also undertaken by the senior coroner speaking to them and the team they work with. The appraisal scheme was met with support from all involved and as expected there were no concerns raised. The reports of the three assistant coroners were submitted to the chief coroner's office for his review.

- Phased introduction of the medical examiner (ME) scheme – in 2019 there was planning for this scheme. There are two schemes being set up both currently linked to the hospitals. One scheme is for the Bristol and Weston hospitals and the other is for the Royal United Hospital in Bath. There has been close liaison with the senior coroner and the Bristol and Weston trusts in setting up the ME scheme and processes.

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

- The court audio/recording equipment was replaced in August 2019 which has already resulted in a considerable saving; one inquest alone saved a significant sum of money being paid to experts to attend the court to give evidence. What would have previously happened is an expert would travel to the court to give their evidence – often taking a day of their time. In fact what happened was they attended through a video link from their place of work. Therefore instead of paying for a whole day what was actually paid to the expert was the time they actually spent giving their evidence. In addition this can be used for prisoners giving evidence from the prison. It is also likely that the system will be utilised during the pandemic.

6. Additional Key Achievements and Challenges in 2019/2020

- A part time area coroner was appointed to the Avon area and started work following his appointment in June 2019 (this is a 0.8 full time post.) This post was filled by an experienced assistant coroner from the existing Avon team. In addition a very experienced and dedicated assistant coroner retired in September 2019. This resulted in a change to the coroner team by the end of 2019 which previously comprised of the senior coroner and five assistant coroner's; the team by the end of the year comprising

of the senior coroner, an area coroner and three assistant coroners. The impact of these changes is being reviewed.

- Avon has a team of seven coroner's officers, one who is also the senior coroner's officer for Avon and Somerset; of the other six, one was a temporary post but this has now been made permanent.

- The Chief Coroner provides detailed guidance to coroners on various matters relating to the Coroners and Justice Act 2009, and also occasionally on the law, following an important case. These are written to assist coroners with the law and their legal duties, and to provide commentary and advice on policy and practice. In 2019 the guidance issued comprised of: "Judge-led inquests"; "Death Referrals and Medical Examiners"; "Suspension, Adjournment and Resumption of Investigations and Inquests".

- There continues to be a national shortage of Consultant Pathologists who are prepared to undertake coronial work – specifically to carry out post mortem examinations. The reasons for this are multifactorial, but include the fact that less pathologists are trained to carry out post mortems; the fact that the work in Avon is carried out at Flax Bourton mortuary which is some distance from the hospitals where the pathologists are employed in their substantive role; in addition the fee paid to them for this work has not increased for many years. The knock on effect for the work of the coroner is that a backlog can be created resulting in a delay in the examination being performed and a delay in releasing the body to the family for the funeral. In 2019 there was a change to the structure of the way payments are made to pathologists and it is hoped that this will improve matters locally.

- There are two courts at Flax Bourton one which is a medium sized court room which can also accommodate a jury (pre-covid); the other (known as court two) is much smaller. Court one underwent some much needed refurbishment this year and court two requires some refurbishment.

- At the end of the year which this report covers coronavirus brought significant challenges. At the beginning this resulted in lockdown. Staff had to work from home and the office was covered by a reduced staffing level. Court had to be cancelled, this meant that many families were disappointed and will ultimately result in there being significant delay to the completion of many cases. The senior coroner attended many meetings in relation to planning with: the Avon and Somerset Local Resilience Forum (ASLRF); police; local authorities; mortuaries; Registrar's; The Chief Coroner, and many others. Much of the planning which has and is taking place will fall to next year's report.

7. ***Coroner Statistics 2019***

The statistics for Avon for the years 2006 – 2019 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 (MOJ) annually with the Office for National Statistics (ONS), and for 2019 they were produced on 14th May 2020. The updated version is available to review for the whole of England and Wales by following this link:

https://www.gov.uk/government/publications/coroners-statistics-2019/coroners-statistics-2019-england-and-wales

Last year's report reflected on the Chief Coroner's annual report but at the time of writing this report has not been published.

In 2019 according to the MOJ report 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 in the long term; that said according to the statistics there have been no amalgamations since August 2018. The purpose of reducing the number of coroner areas include: establishing coroner's areas of similar size; to reduce the number of part-time senior coroner's; to achieve greater consistency and for cost savings.

Based upon the numbers of deaths reported Avon was the 9th largest area in 2018 with 4,027 (deaths reported), it is now the 5th largest with 4,045, the largest being Nottinghamshire with 6,781 (deaths reported).

In 2018 the average time to process an inquest (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. In 2019 this figure has increased slightly both for England and Wales and Avon, with the average being 27 weeks for England and Wales and for Avon that figure being 18 weeks; 9 weeks less than the average for England and Wales.

Post mortem examinations conducted as a percentage of the number of deaths reported in 2018 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 2019 this figure for Avon was 33% with the figure for England and Wales being 39%.

This shows that in Avon the number of post mortems being conducted as a percentage of the number of deaths reported has reduced.

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

It is a requirement that senior coroner's complete a notification each year at the end of April detailing those cases which have not been concluded within 12 months. This report includes 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 many which 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 effectively the coroner's investigation being put on hold pending the outcome of those other investigations which are often delayed or lengthy.

Reason for delay	**2016**	**2017**	**2018**	**2019**
Death abroad	1	3	3	2
Investigation/Prosecution by external authority	9	3	6	5
Complex case	2	2	2	5
Prepared for inquest			1	3
Current criminal proceedings in the Crown Court				6
Total for the year	**12**	**8**	**12**	**21**

8. 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 2019 are detailed in Annex B

9. Future Developments:

This year so far has been dominated by the coronavirus pandemic and will no doubt continue to dominate the service; the plans at this time therefore include:

- The management and a desire to return to business as usual performance and recovery linked with the pandemic.
- 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. The 2 medical examiner systems in the Avon area will initially only cover hospital deaths, with deaths in the community to be included at a later date.

10. Acknowledgements

The staff who support the senior coroner all work incredibly hard to ensure that standards are maintained and all deaths are investigated and handled in a professional and expeditious way.

The senior coroner would also like to acknowledge the work of the area and assistant coroners, having conducted appraisals this year it is clear that they continue to demonstrate their judicial impartiality and professionalism whilst maintaining the highest standards.

The senior coroner would like to thank the team for their continued commitment.

Finally, the Coroner's Court Support Service, the team of volunteers who offer support to bereaved families and other witnesses when attending court – thank you.

Maria Eileen Voisin

HM Senior Coroner

Annex A: Statistics from 2006 – 2019

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%
2019	4045	18	27	644	728	16%	14%	1345	33%	39%

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

1.

Deceased name: Christopher Michael Seal
Date of report: 10th January 2019
Report sent to: Avon and Wiltshire Mental Health Partnership NHS Trust
Report by: M E Voisin

INVESTIGATION and INQUEST

"… Christopher Seal died on 30th November 2017 at the playing fields, Bath Spa University, Newton St Loe, Bath. He had placed a rope around his neck and was found suspended from the rugby posts, he had intended to take his own life."

CIRCUMSTANCES OF THE DEATH

"Chris's death was due to suicide. However in the 5 days leading up to his death he was under the care of the mental health team. On 26th and 27th November Chris had been assessed as high risk and the plan was to assess him in the community as he indicated he was willing to engage. On 27th and 28th November he failed to respond to calls and disengaged from the service. On 29th November he cut his wrist and was assessed as high risk again by the mental health liaison team at the hospital and the plan remained the same, there was an underestimation of his condition at this assessment. Chris failed to be at home for the assessment immediately following his discharge. A welfare call to the police was made but the important information from the police following the welfare check was not relayed to the team or recorded in the records as it should have been. The cold call to Chris's property on 30th November resulted in the only action of leaving a letter with another appointment; there was no escalation as suggested in the "no response and police welfare check requests procedure" which is only a guide for patients in primary care as no policy exists. Finally there was no contact made with the family during 29th or 30th due to a poorly completed information sharing form. "

CORONER'S CONCERNS

"… The MATTERS OF CONCERN are as follows: –

1. The information sharing form – in this case it was not explicit as to whom information could be shared with hence the family were not informed or contacted; is there an issue with the form itself to make this clearer for clinicians to be more explicit or is there a training issue for the staff involved with completing this form?
2. On the RIO records system I was advised that it put the first information sharing form as the most recent when it wasn't, in this case there was a more recent form, this misled the staff, although both forms were clearly completed and on the RIO system – is this a technical matter with IT or is this a training matter for the staff using the system?
3. There were no next of kin details recorded on RIO – I was told that you use The National Spine to automatically populate this information however the next of kin details were on

the hospital records for the A&E attendance and I was told that they use The National Spine. Is this system being used properly?

4. The demographics page in RIO – in this case it was incomplete and I was told it often is – is this training issue for the staff or again a technical matter with the RIO system?
5. I was told that there is no "no response policy" for those in primary care; that the policy which exists is for secondary or tertiary care and is therefore not applicable to the service users or staff in primary care. This would also raise the question of training
6. I was told that there is no "welfare check policy" for those in primary care; that the policy which exists is for secondary or tertiary care and is therefore not applicable to the service users or staff in primary care. I was told that Avon and Somerset Constabulary are in the process of writing a "welfare check policy" and it may be beneficial for there to be liaison with the police forces in the AWP area to ensure that any new policy that you consider is appropriate is in line with their expectations as to what a police officer can and will do following such a call. This would also raise the question of training.
7. RIO entries generally – I was told that there is an expectation that staff are expected to make their entry onto the RIO system within either 72 hrs. or 24hrs. Is this in line with what professional bodies expect and should it be?
8. The intensive service switchboard – is there an issue in relation to the training of staff and their ability to react to protecting life? I was told they do not have ability to call 999 but that they advise the service user to make the call, is that appropriate?
9. Contact with service user – I was told that the preferred method is verbal contact and the only other means is a text message with this being care planned. In this changing world of communication should other care planned options be considered such as email or messaging?"

2.

Deceased name: Elizabeth Rose CURTIS

Date of report: 11th January 2019

Report sent to: NHS Improvements

Report by: M E Voisin

<u>INVESTIGATION and INQUEST</u>

" …Elizabeth Curtis was admitted into the Royal United Hospital, Bath on 17th March 2018 with a urinary tract infection and delirium; she was treated and prescribed antibiotics to treat the infection and Haloperidol to treat the delirium. She should have been prescribed 0.25mg but in fact was prescribed 2.5mg. of Haloperidol. The drug error was noted and the drug was stopped. Mrs. Curtis had a number of comorbidities including the fact she was 90, that she was frail, had chronic kidney disease, Crohn's disease and had a swallow problem. Mrs. Curtis developed aspiration pneumonia on 26th March and died on 31st March 2018 at Royal United Hospital Bath"

CIRCUMSTANCES OF DEATH

"Mrs Curtis died from aspiration pneumonia contributed to by a number of factors including: her age and frailty; her pre-existing underlying medical conditions; a problem with her swallow, an infection and delirium which required treatment with haloperidol. The drug haloperidol may also have had a minimal impact on her developing pneumonia."

CORONER'S CONCERNS

" ...The **MATTERS OF CONCERN** are as follows. –

A patient's mobility became an issue at the inquest and how this can help with assessing a patient's wellness.

I was advised by [redacted] at the Royal United Hospital, Bath, who gave evidence at this inquest that she was introducing to the hospital a mobility scale due to the impact that mobility or indeed frailty has on assessing well-being of patients when in hospital.

[redacted] has indicated that this is a simple scale noting a patient's best mobility in the previous 24hrs. and is recorded alongside the NEWS score. Often mobility is the first symptom demonstrating a decline in health. I am told that the Royal United Hospital have adopted this scale.

For further details in relation to this I would suggest that you contact [redacted] Consultant Geriatrician, at Royal United Hospital NHS Foundation Trust her email is [redacted]
I have also suggested that she write to you to outline her "mobility scale", hence I have copied her into this report."

3.
Deceased name: Evie WRIGHT
Date of Report: 15th February 2019
Report sent to: Persimmon Homes Severn Valley and North Somerset Council
Report by: M E Voisin

INVESTIGATION and INQUEST

"... Box 3 on the Record of inquest read: "Evie Wright died on 6th March 2018, 100 yards north of Corondale Crossing, Weston Super Mare. She had walked onto the railway line and into the path of a train which struck her causing her to suffer multiple injuries and her immediate death. "

CIRCUMSTANCES OF THE DEATH

" The conclusion in Box 4 read: "Evie Wright died when she was struck by a train her intention when she walked onto the train line is unknown."

CORONER'S CONCERNS

"… The MATTERS OF CONCERN are as follows. –

In this case I heard evidence from Network Rail and North Somerset District Council.

That evidence confirmed that the level crossing used by Evie at the time was risk assessed as complying with the standards set.

However I also heard that in the vicinity of the crossing there was planning permission in place to build a footbridge. I have been told that such had been the position since 1991; that it was an obligation on the builder at the time to build a footbridge; that planning permission had been granted in 2000.

I heard a number of reasons and explanations for why this has not happened.

I was told that there are now plans in relation to a new footbridge which is different in construction and that its location has moved hence it requires a fresh planning application and permission.

I have heard that a footbridge would enhance safety and eliminate risk, that network rail supports the closure of any crossing but has no power or responsibility – that rests with the North Somerset District Council and the developer – now Persimmon, who it should be noted were not the original developer."

4.

Deceased name: Marcie TADMAN

Date of Report: 13th March 2019

Report sent to: Royal United Hospital, Bath and Accountable Office, BANES CCG

Report by: M E Voisin

INVESTIGATION and INQUEST

"On 04/07/2018 I commenced an investigation into the death of Marcie Joan TADMAN. The investigation concluded at the end of the inquest 12th March 2019.

The conclusion of the inquest was Natural Causes Contributed to by Neglect "

CIRCUMSTANCES OF THE DEATH

"Marcie Tadman died on 5th December 2017 at Royal United Hospital, Combe Park, Bath. She had been admitted to hospital on 4th December 2017 with pneumonia and parapneumonic effusion. She was not referred to the regional unit for treatment of this condition. She had sepsis and there was a failure to recognise and to manage and/or treat sepsis. There were failures to follow the procedures and protocols set nationally or by the hospital. The communication each and every time when discussing Marcie between members of the team was unsatisfactory. All handovers failed to take the opportunity to

review Marcie with fresh eyes. The combination of: poor communication between all staff caring for Marcie; the failure to follow any hospital protocols; the lack of proactive review and poor decision making came together to contribute to her death.

The medical cause of death:

1a Disseminated group A streptococcal infection including empyema, bronchopneumonia and pyelonephritis"

CORONER'S CONCERNS

"... The MATTERS OF CONCERN are as follows. –

RUH

- I heard from the independent expert [redacted] that the only opportunity for Marcie to be picked up with fresh eyes would have been at another ward round.

I understand that this would be an opportunity for a Consultant to take a step back and review the notes, charts, PEWS and results; examine the patient and to make a plan. In Marcie's case everyone agreed that all of the information was there in her records but no one carried out this exercise; there was and is no second ward round on the paediatric ward at the RUH.

I indicated to the RUH that I had received further information from [redacted] in relation to a second ward round and this is attached.

Accountable Offices for BANES CCG

- I was also made aware at the inquest that there is no High Dependency Unit (HDU) facility on the RUH paediatric ward for children in their care and this was something that they were hoping to provide but needed to create a business case to the Accountable Offices for BANES CCG for this.

In Marcie's case she should/would have been placed in such a unit had one been at the RUH at the time. "

5.

Deceased name: Alexander GREEN

Date of Report: 1st April 2019

Report sent to: Chief Executive, Royal United Hospital, Bath

Report by: M E Voisin

INVESTIGATION and INQUEST

"On 25/10/2017 I commenced an investigation into the death of Alexander Frederick Richard GREEN. The investigation concluded at the end of the inquest 29th March 2019.

The conclusion of the inquest was Accident contributed to by neglect"

CIRCUMSTANCES OF THE DEATH

"Alexander Green died on 3rd October 2017 at Southmead Hospital, Westbury-on-Trym, Bristol. On 30th September 2017 he was out for a night socialising with friends and was seen to fall. Around 1 hour later at 03.59hrs an ambulance was called when Alex was found lying in the road by passers-by. He was taken Royal United Hospital, Bath and was handed over as intoxicated; his Glasgow Coma Score was 13/15 but he was not seen until 07.20hrs by a doctor who did not diagnose his head injury. Instead Alex was handed over as intoxicated. Alex was not reviewed again that morning by a doctor. At 14.05hrs he suffered a respiratory collapse; a significant head injury was diagnosed which included a fractured skull and haematoma. He was transferred to Southmead Hospital where he underwent treatment; but due to the delay in diagnosis and transfer the treatment provided was futile. He died due to the injuries he suffered in a fall."

CORONER'S CONCERNS

"… The MATTERS OF CONCERN are as follows. –

1. The handover at around 8am resulted in a failure to challenge and communicate effectively.
   Handovers need to be considered across the whole of the trust not just the emergency department to ensure they are appropriate and effective.
   The reason I include this as a trust wide matter of concern is that I have recently dealt with another case where there were failures in the handover on another ward at the Royal United Hospital.
   I have been advised that other hospitals use the SBAR tool at handovers to assist in communication.

2. The NICE guideline for head injury was not considered appropriate for use in this case when it is clearly designed for exactly this case – you ascribe depressed conscious level to intoxication only after a significant brain injury has been excluded.

3. There was an assumption by everyone managing Alex that he was intoxicated when in fact he had a significant head injury; SWAST I am told have developed training in relation to bias (and intoxication is included in that). "

6.

Deceased name: Benjamin MURRAY
Date of Report: 2nd May 2019
Report sent to: Bristol University, The Department of Education, The Minister for Suicide Prevention, UCAS
Report by: M E Voisin

INVESTIGATION and INQUEST

"On 30/05/2018 I commenced an investigation into the death of Benjamin James Charles MURRAY. The investigation concluded at the end of the inquest.

The conclusion of the inquest was: suicide"

CIRCUMSTANCES OF THE DEATH

"On 5th May 2018 Ben had lunch with his father and left him shortly before 2pm. His father's statement stated that: "he seemed somewhat down and I was concerned because he was sensitive but the thought that he would take his own life never crossed my mind"

At 3pm Ben was found beneath the Clifton suspension bridge on the canopy area, the police officer reviewed the CCTV footage from the bridge, he described what he saw - that Ben walked unaccompanied onto the bridge, he walked to the buttress wall, climbed up onto it and without hesitation propelled himself forward.

It was clear from the investigation that there were a number of matters going on in Ben's personal life including: that Bristol was not Ben's first choice of university to study at; that he never seemed to fully engage with University studies; that his place at University had been withdrawn; that there was a significant debt owed to the University for tuition and accommodation; that Ben had disclosed that he was suffering illness and anxiety and it appears that he may have been confused about his status with the University."

CORONER'S CONCERNS

"… The MATTERS OF CONCERN are as follows. –

1. **For Bristol University, The Department of Education and The Minister for Suicide Prevention**

Bristol University have clearly made many fundamental changes to their practices to support students wellbeing and it may be that their current practices can be shared throughout the Higher Education sector to assist with suicide prevention.

2. **For UCAS, The Department of Education and The Minister for Suicide Prevention**

The concern over mental health disclosure either on the UCAS application form or indeed to a prospective University.

I am told that currently such disclosure is at 37%. There needs to be a move towards de-stigmatising mental health and ensuring that students are made aware that by disclosing mental health problems on their UCAS form or to their prospective University that it will not affect getting a place at University.

3. **For Bristol University, The Department of Education and The Minister for Suicide Prevention**

The transition from home to University can be a challenging time for some students and Universities clearly have the primary role of education however this inquest has demonstrated they also carry out an important pastoral role.

It is not the role of the Coroner to investigate Ben's journey through University in light of the circumstances of his tragic death and the limited scope. That said as a Coroner has a duty to consider prevention of future deaths it was appropriate in this case that aspects of Ben's progress were investigated by me.

In addition currently the University sector does not carry out an investigation report (such as a root cause analysis or sudden untoward investigation) after a death of a student. Such a written report usually affords an opportunity to review what happened; what was done well/the good practice points; areas of concern, if there are any, and importantly what lessons can be learned often with a formal written action plan. Such a document is also very helpful to the Coroner when considering and discharging this duty. Such a formal process and document most importantly assists in preventing future deaths. "

7.
Deceased name: Natasha ABRAHART
Date of Report: 16th May 2019
Report sent to: Avon & Wiltshire Mental Health NHS Trust, The Student Health Service, Secretary of State for Health [redacted] Minister for Suicide Prevention [redacted]
Report by: M E Voisin

INVESTIGATION and INQUEST
"On 16/05/2018 I commenced an investigation into the death of Natasha Elizabeth Victoria Abrahart.

The investigation concluded at the end of the inquest 16th May 2019.

The conclusion of the inquest was: Suicide contributed to by neglect

The medical cause of death was 1a)Hanging"

CIRCUMSTANCES OF THE DEATH
"Natasha Abrahart died on 30th April 2018 at First Floor Flat, 58 Park Street, Bristol; she had locked her bedroom door, placed a ligature around her neck and died as a result. At the time of her death she was under the care of the mental health team who had not provided a timely and detailed management plan following a number of assessments by them. That management plan should have been in place by the end of March 2018 and by the time Natasha was on her Easter holiday which would have instilled hope and managed her risk. "

CORONER'S CONCERNS
"... The MATTERS OF CONCERN are as follows. –
The NICE guideline Depression in Adults; Recognition and management (CG90) states in section 1.5.2.7 "A person with depression started on antidepressants who is considered to present an increased suicide risk or is younger than 30 years (because of the potential increased prevalence of suicidal thoughts in the early stages of antidepressant treatment for this group) should normally be seen after 1 week and frequently thereafter as appropriate until the risk is no longer considered clinically important"

In this case Sertraline was prescribed but the NICE guideline was not followed by the mental health trust or the GP practice.

The expert indicated that the review at 1 week is to ensure that the patient is taking the medication, to check for any side effects including suicide risk and to see what has happened; that review can be done by the G.P. or the mental health team but there needs to be a known appointment."

8.
Deceased name: Abdeslam BENELGHAZI
Date of Report: 10th October 2019
Report sent to: **The Rt Hon [redacted] MP Secretary of State for Health and Social Care**

Report by: M E Voisin

INVESTIGATION and INQUEST
"On 10/01/2018 I commenced an investigation into the death of Abdeslam BENELGHAZI. The investigation concluded at the end of the inquest on 9th October 2019.

The medical cause of death: 1a) combined effects of methadone, zuclopenthixol, gabapentin, clonazepam.

The conclusion of the inquest was: Accident contributed to by neglect with a narrative which stated "As the jury, we conclude that the inappropriate prescribing of combined medications alongside the failure to adequately monitor and escalate concerns significantly contributed to the death of Abdeslam Benelghazi"

CIRCUMSTANCES OF THE DEATH
"The deceased, known as Abde throughout the inquest was a patient detained under Section 2 of the Mental Health Act.

The medical diagnosis for Abde being schizophrenia co-existing with mood changes known as schizo-affective disorder. This was treated with the anti-psychotic zuclopenthixol and mood stabilizer sodium valproate.
The deceased was also taking gabapentin for chronic neuropathic pain and methadone to moderate, treat and to cease his use of heroin. The last recorded time that Abde had methadone was 35mgs on 30th November 2017.

In addition he was prescribed clonazepam. This prescription was started when Abde was at the Cygnet Hospital in Weston (2nd – 7th December 2017) when he was not initially taking methadone, the Consultant said clonazepam and diazepam were prescribed to help with withdrawal. He was given 20mgs of methadone at the Cygent Hospital on 5th and 6th December.

When the deceased was transferred to The Long Fox Unit at Weston General Hospital on the 7th December 2017 his prescription of methadone was increased and the clonazepam remained. I attach a list of the medications prescribed and administered.

The jury found in that…

"the factors that contributed to his death include:

i) Increasing the dosage of methadone beyond the normal limits set out in recognised guidance:
ii) Continuing clonazepam, a drug known to be associated with an increased risk of death when taken in conjunction with opiates, without establishing the reason for the original prescription:
iii) Having taken the steps set out above, failing to put in place an adequate pharmacological care plan to assess, monitor and review the patient and to communicate it to relevant staff:
iv)Upon the patient presenting with signs of over sedation and/or reduced consciousness on at least three occasions in a 48 hour period, the failure of the medical and nursing team, notwithstanding the absence of a pharmacological care plan, to initiate any medical investigation or intervention including enhanced physical and/or non-contact observations. And furthermore the failure to administer naloxone"

Abde died on 9th December 2017."

CORONER'S CONCERNS

"... The MATTERS OF CONCERN are as follows. –
An expert was instructed to assist in this case namely [redacted] who practices in general adult psychiatry with a special interest in the psychiatry of addition.

He agreed with the medical cause of death, that the drugs Abde was prescribed specifically methadone with other sedative medications zuclopenthixol, gabapentin and clonazepam can cause a combined effect of central nervous system depression and respiratory depression increasing the risk of sudden death.

He expressed a particular concern in relation to the prescribing of clonazepam with methadone. The reasons he gave were that clonazepam has a long half life; side effects include respiratory depression; that one supplier of clonazepam states "concomitant use of clonazepam with opioids may result in sedation, respiratory depression, coma and death"; that clonazepam is a means of delivering a high equivalent dose benzodiazepine without exceeding BNF limits.

He said that in this case clonazepam may have been the drug that tipped the balance. "

9.
Deceased name: Shaun DEWEY
Date of Report: 19th November 2019
Report sent to: [redacted] **Director General – Prisons, HM Prison and Probation Service**
Report by: M E Voisin

INVESTIGATION and INQUEST
"On 09/05/2018 I commenced an investigation into the death of Shaun William Dewey. The investigation concluded at the end of the inquest 18th November 2019. The inquest was held with a jury who found that …

"Shaun William Dewey died on the morning of the 13th April 2018 in his cell on 'A' Wing at HMP Bristol from compression of the neck, having suspended himself from a ligature tied to the bed frame.
Shaun's own anxiety, depression and separation from his family, was exacerbated by uncoordinated supervision and erratic medication use. These were all contributory factors to his state of mind and ultimately his death.
Although there were prison, health-care and mental health care systems in place to safeguard Shaun, they were insufficiently applied to prevent his death."

The conclusion of the jury was recorded as:
"Suicide - with narrative.
Although Shaun's presentation did not necessarily signify his intent, there were instances during his remand when the systems in place failed to identify issues and act upon them, for instance a previous significant act of self-harm, which was not highlighted or picked up on, during transfer from HMP Hewell.
On occasions when signs were identified, there was failure to act sufficiently and there was a tendency to close actions, before issues were fully resolved.
In the last weeks of Shaun's life the Jury believes there were sufficient signs to warrant the opening of another ACCT."

CIRCUMSTANCES OF THE DEATH
"The deceased who was a remand prisoner was found hanging in his cell at HMP Bristol."

CORONER'S CONCERNS
"… The MATTERS OF CONCERN are as follows. –
During the inquest I was made aware of 2 reports the first was The Prisons and Probation Ombudsman – "Learning from PPO Investigations, Risk Factors in self-inflicted deaths in prison" published in April 2014 which was a review of deaths investigated between 2007 and 2013 and stated:

- On page 12 of the report paragraph 3.1 "… remand prisoners … made up 43% of the deaths … but are only 13% of the total prison population"
- on page 21 of the report paragraph 5.5 "…it is surprising remand is not specifically highlighted in the current context section of the list of risk factors of PSI 64/2011"

Next I was referred to a Ministry of Justice document published 31st January 2019 "Safety in Custody Statistics, England and Wales: Deaths in Prison Custody to December 2018 Assaults and Self-harm to September 2018" this report on page 9 states "Prisoners who were in custody serving indeterminate sentences …. or were on remand (2.91 per 1,000 prisoners) had a higher rate of self-inflicted deaths than all determinate sentences .."

My concern is therefore whether the risk of remand prisoners being at higher risk of self-harm or suicide should be:

- considered by those designing the training for staff;
- a factor generally highlighted to those caring for prisoners including prison staff and healthcare teams that is both the mental and physical health teams.
- a risk highlighted on the ACCT document or
- reflected in any re-draft of PSI 64/2011 national guidance – "Management of prisoners at risk of harm to self, to others and from others (safer custody)"

10.

Deceased name: Alice SLOMAN

Date of Report: 16th December 2019

Report sent to: University Hospitals Bristol NHS Trust, Torbay and South Devon NHS Foundation Trust

Report by: Dr Simon Fox QC

INVESTIGATION and INQUEST

"On 02/11/2018 an investigation into the death of Alice Marie Sloman was commenced. The investigation concluded at the end of the inquest on 16th December 2019. The conclusion of the inquest was a narrative conclusion as follows:

Alice was born with a mitochondrial disorder resulting in her developing cardiomyopathy, skeletal myopathy, short stature and Autistic Spectrum Disorder. Her medical management was lacking in that investigations to diagnose her underlying condition were not undertaken. As a result her cardiomyopathy was not diagnosed and she died from complications of a routine general anaesthetic."

CIRCUMSTANCES OF THE DEATH

"Three days before her death Alice underwent a routine general anaesthetic for an MRI scan. The medical staff were unaware that she had a cardiomyopathy. The anaesthetic precipitated a cardiac decompensation from which she never recovered."

CORONER'S CONCERNS

"… The MATTERS OF CONCERN are as follows. –

The evidence demonstrated that Alice was under the care of a consultant community paediatrician, a consultant general paediatrician with an interest in endocrinology and a consultant paediatric endocrinologist presenting with a number of conditions (Growth

hormone deficiency, Autistic Spectrum disorder, developmental delay, visual impairment, mobility impairment, poor coordination/dyspraxia and hypermobility) over a 9 year period but was not referred for investigation of an underlying disorder, specifically a clinical geneticist's opinion, despite her parents requesting this on at least 2 separate occasions which are documented and despite such facility being readily available in Exeter. The evidence demonstrated that as a result her underlying condition, and specifically a serious cardiomyopathy, went undiagnosed resulting in her dying unexpectedly and prematurely as a result of a routine general anaesthetic."