Maria Eileen Voisin

HM Senior Coroner for the Area of Avon

Annual Report

2023/2024

Contents

1. ***Introduction***

This report for the Coroner area of Avon, covers the period from approximately April 2023 to March 2024.

However, due to the timing of when national statistics are produced, the report considers those for the year 2023. 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 and commented on in the Avon annual report. This year that report is to be provided in the autumn of 2024, therefore this report only comments on the overall number of cases over 12 months old and not the detail.

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

Finally, the important role of a Coroner includes making reports to appropriate organisations to prevent future deaths. This includes details of the reports made during 2023.

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

Coroners are not local authority employees and are independent of both local and central government. 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, Coroner's also investigate deaths in state detention whether the cause is natural or unnatural.

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: the identity of the deceased; the place of death; the date of death; and how they came by their death.

The provision of staff and accommodation is covered under s 24 The Coroner's and Justice Act 2009 which states …
"(1) The relevant authority for a coroner area—
(a) must secure the provision of whatever officers and other staff are needed by the coroners for that area to carry out their functions;
(b) must provide, or secure the provision of, accommodation that is appropriate to the needs of those coroners in carrying out their functions;
(c) must maintain, or secure the maintenance of, accommodation provided under paragraph (b).
(2)Subsection (1)(a) applies to a particular coroner area only if, or to the extent that, the necessary officers and other staff for that area are not provided by a ***[****F1local policing body****]****."*

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

- The ongoing management of an increased and more complex caseload whilst maintaining standards – This remains the single most significant challenge.
- Pressures on court accommodation and specifically the continued funding and therefore use of Ashton Court beyond April 2024. During the Covid pandemic Ashton Court enabled jury and complex inquests to be listed at a more suitable venue (allowing for social distancing) and since to manage the backlog of jury cases – Limited funding for court accommodation over and above that which is provided at Flax Bourton has been agreed for a further three years, so ending April 2027.
- The medical examiner system moving into the community – This has been progressing over the last year. As of 9th September 2024, a new death certification process comes into force. From that date, all deaths in England and Wales will be independently reviewed, without exception, either by a medical examiner or a Coroner.
- The process for managing a death in the community out of usual business hours – The new system was launched and is still in the pilot phase.
- The introduction of a system for reporting a death to the Avon team via a portal for professionals to use. – The portal was launched on 4th October 2023, some doctors are now using this to report a death.

4. Additional Key Achievements and Challenges in 2023/2024

- In last year's report I outlined the team structures. At that time there were five assistant coroners. In December 2023 two new assistant coroners were appointed and in March 2024 there was a resignation by an assistant who had been in post since 2014. That leaves a team of six assistant coroners.
- Recruitment for a coroner's officer took place and the successful applicant began work with the team in February 2024.
- Funding was also secured for an additional coroner's officer in February 2024, that post will be filled in September 2024. That will increase the team from six to seven plus the part-time senior coroner's officer.
- The Senior Coroner's Officer supervises both the Avon and Somerset coroner's officer teams. At the time of writing the annual report last year, they worked virtually full time in Avon, managing a full caseload of investigations and inquest files, as well as

supervising both teams. During the year, the decision was taken that the time spent in Avon would be reduced to part-time. This had a significant impact on the role and the workload of the team. Somerset chose to recruit a full-time Senior Coroner's Officer, which resulted in the current postholder transferring to the Somerset Coroner area. The post in Avon remains part-time. At the time of writing this year's report that post is essentially vacant but being covered temporarily by the outgoing senior coroner's officer.

- The admin team is small with three full time members of staff. This year it was agreed that the team should have some holiday cover to ensure that essential work is still progressed.

- Over the last year we managed to conclude a significant volume of cases as you will see below and in addition, we also managed to conclude a significant volume of jury cases. This is where care needs to be taken with comparing the numbers of cases with the types of cases. The work and time involved with a straightforward inquest cannot be compared with a case which is complex, involving, multiple interested persons, voluminous documents, statements of witnesses and often the need for independent expert evidence. Last year between April 2022 and March 2023 there were 10 jury cases concluded totalling 10.5 weeks of court time. This year between April 2023 and March 2024 there were 6 jury cases concluded totalling 12 weeks of court time. From now we already have 12 more jury inquests listed, totalling 21 weeks court time with approximately 30 more jury cases in the system yet to be listed.

- The jury facility at Flax Bourton was significantly improved this year with the provision of a kitchenette for the jurors use. This enabled some juries to be heard at Flax Bourton again. However, due to the volume of non-jury inquests and limited court space at Flax Bourton, there is still a requirement to use alternative court accommodation. Funding for the use of additional court accommodation has been approved for 3 years, but finding suitable court accommodation at an appropriate cost is time consuming and challenging.

- This year there has been a significant increase in the number of unnatural deaths from the prison estate in Bristol. An unnatural death in custody requires a jury inquest and as such it usually results in an inquest that is complex and takes some considerable work to conclude. The length of a prison jury inquest is on average 2-3 weeks. There are 4 prisons in the Avon area.

- The complexity of cases is increasing, a fact which is now accepted widely amongst Coroner's and those working in the service. This fact needs to be built into future planning for the Avon Coroner's service and should include provision of sufficient staffing levels, appropriate accommodation and courtroom facilities.

- Stakeholder meetings have 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. These meetings are to discuss matters related to the Coroner service.

- The mortuary at Flax Bourton, which is responsible for carrying out post-mortem examinations on behalf of the Avon Coroner, has been extended. This has increased its storage capacity from 135 to 250, including bariatric, isolation and freezer storage. This will ensure the mortuary has the capacity to appropriately care for the deceased, even through periods of increased demand. During the build phase there were occasions when the noise from the build impacted on the hearings at the Coroner's Court and some inquests had to be heard at alternative locations. An ongoing impact of the mortuary build is that of the associated planning requirements for bicycle storage and electric charging points. This has and will significantly reduce available parking on site for those attending inquests including families and jurors. There is limited alternative parking in the vicinity of the court.

- The portal, for referrals into the Coroner, was launched on 4th October 2023. This has had limited success to date with concerns raised by some GP's and the Medical Examiner service covering Bristol and Weston - those concerns relate to the portal creating work for them which then takes them more time to make the referral. Avon and Somerset Constabulary agreed to fund the work required for police referrals to be made via the portal. That work is still ongoing.

- Procurement took place for deceased transport and the contract was awarded to a new provider.

- Treasure is also a function of the Coroner. Treasure inquests are held to establish whether a find is treasure, who found it, and when and where it was found. If an item is deemed treasure, it becomes the property of the Crown, if it is not it is returned to the landowner. In July 2023 there were changes to the law around Treasure, when essentially the definition of what constitutes treasure was widened. The change means that more finds can be acquired by museums. Currently there are several treasure inquests outstanding. Processing these cases has been made more difficult by the Civica case management system not having the necessary functionality.

- Of interest this year was the Chief Coroner's Annual Report for 2023, in that he reminded Coroner's of the case of *R(Morahan) v West London Assistant Coroner [2022] EWCA Civ 1410*, which stated "… an inquest remains an inquisitorial … process. It is not a surrogate public enquiry". The Chief Coroner referenced the constant pressure on Coroner's to expand the scope. He concluded …

"… the death investigation process has a profound human significance and there is a clear moral basis for placing the deceased at its heart… It does not confer a free-standing right to explore whatever issues families may decide to raise for their own purposes..."

"… the scope should be narrowly focussed on the death … the inquisitorial nature of the coroner service should be protected … issuing prevention of future death reports is an ancillary duty … cases should be conducted without delay …"

This reference (by the Chief Coroner) to the constant pressure on Coroner's reflects our own experience in Avon, with a trend for families being represented by leading counsel.

The Chief Coroner also commented on the tour which he had embarked upon when he visited all Coroner areas. He made a number of general findings … he concluded that the Coroner service generally has insufficient funding; teams are understaffed resulting in avoidable delays with lack of resilience and a knock-on effect on welfare of the staff. That in a model area the caseload of a coroner's officer should be approximately 25 inquest files, subject to the complexity.

To put this into context locally we currently have 6.5 coroner's officers, the workload can vary every single day due to cases referred and concluded but a snapshot today shows 513 open cases, an average of 82 each, with 314 inquests, an average of 48 each. Avon would need a team of 12 coroner's officers to achieve the staffing recommended by the Chief Coroner in this year's report. Staffing levels will need to be reviewed going forward especially after the changes in the death certification process on 9th September 2024.

The Chief Coroner also found that across England and Wales, often accommodation is in a building which is not sufficiently modern or well-maintained with a lack of dedicated courtrooms.

Flax Bourton Coroner's Court is an old building, as such there are regular maintenance issues including damp, mould, drains, heating and the roof. There are also limited facilities for the families, witnesses, legal teams etc who attend the court, by way of example, there has been no ability to obtain a hot drink since 2020 and this is still not resolved.

The Chief Coroner's report also touched on a positive development noting the professionalism of the coroner's service continues to increase and coroners' status as judges is becoming more widely recognised.

5. Coroner Statistics 2023

The statistics for Avon for the years 2006 – 2023 as compared against the national picture appear in **Annex A**.

Comparing coroner areas is fraught with difficulties as has been highlighted in previous reports.

Coroner's statistics are produced by the Ministry of Justice (MOJ) annually together with the Office for National Statistics (ONS), and for 2023 they were produced on 10th May 2024. The latest version is available to review for the whole of England and Wales by following this link:

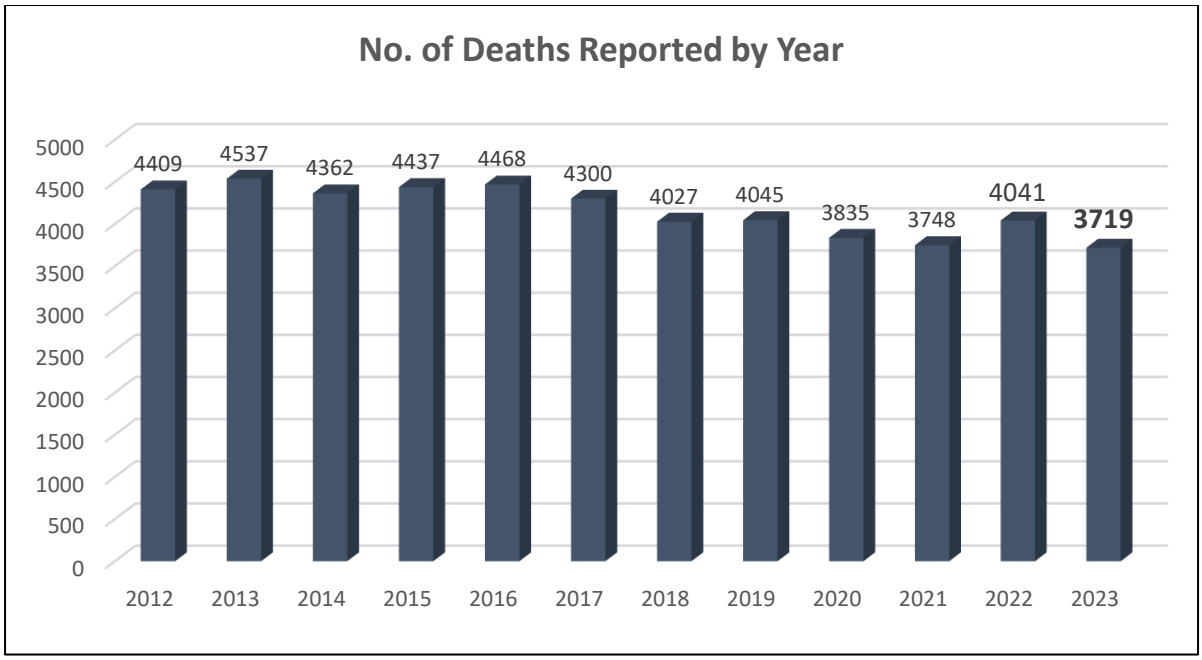
https://www.gov.uk/government/collections/coroners-and-burials-statistics

There are currently 80 Coroner areas 3 less than last year due to mergers.

Based upon the numbers of deaths reported Avon was the 12th largest area in 2023 with 3,719 (deaths reported).

There has been a decrease in the number of deaths reported to Avon in 2023, having had 4,041 reported in 2022 (Figure 1).

Figure 1



In 2023 the average time to process an inquest (from the time the death was reported to the inquest being concluded) in Avon was 24 weeks, compared to the average of 32 weeks for England and Wales over the same period (Figure 2).

Figure 2

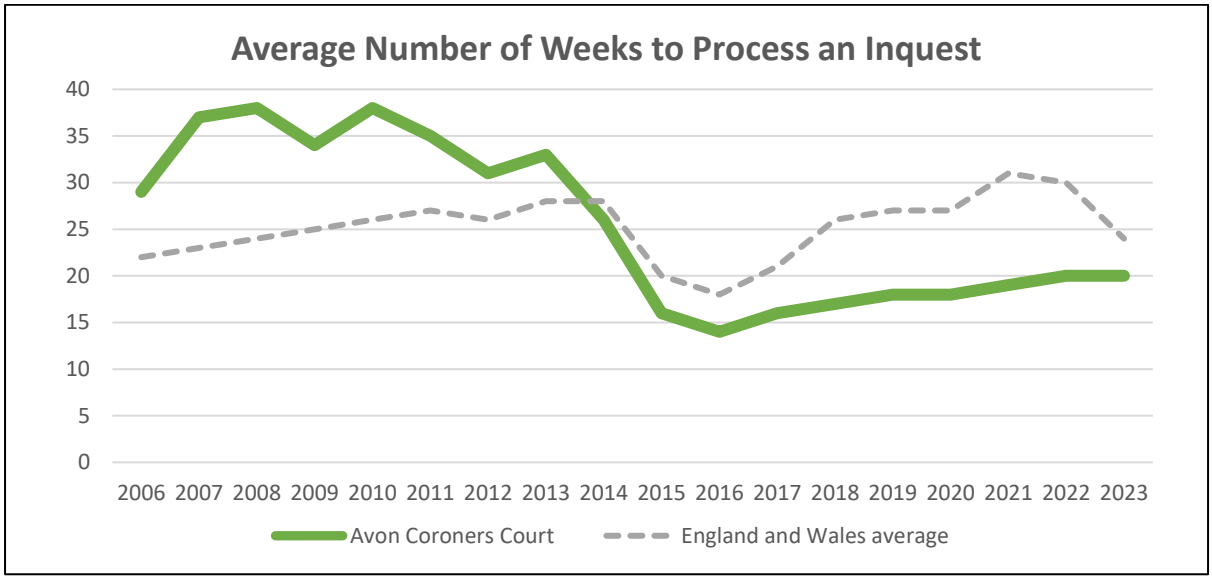
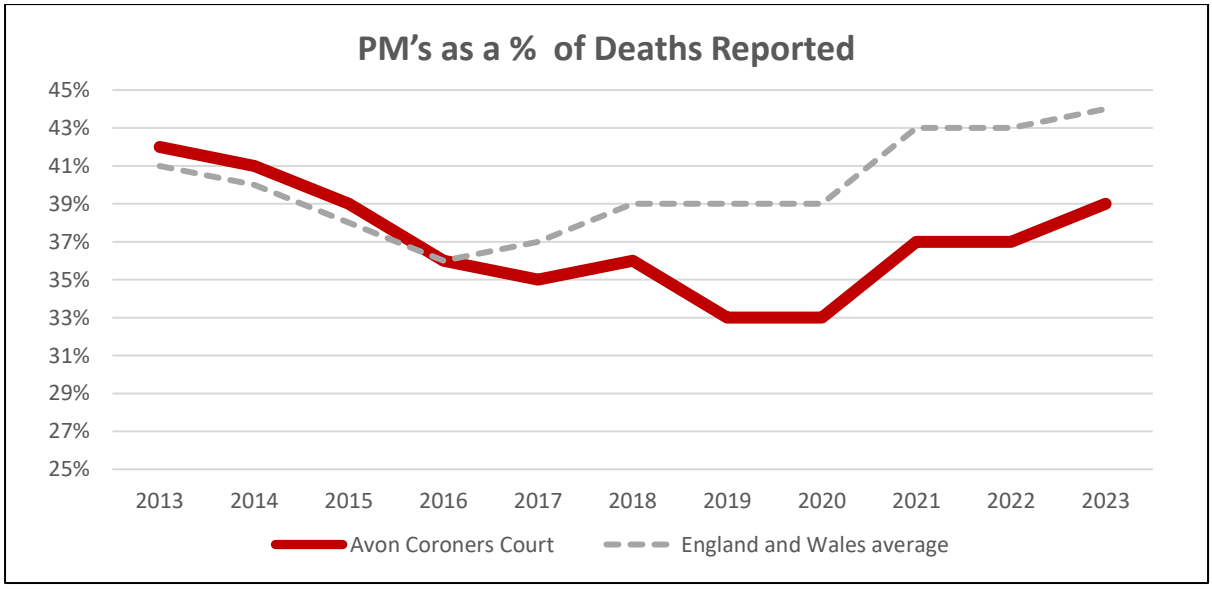


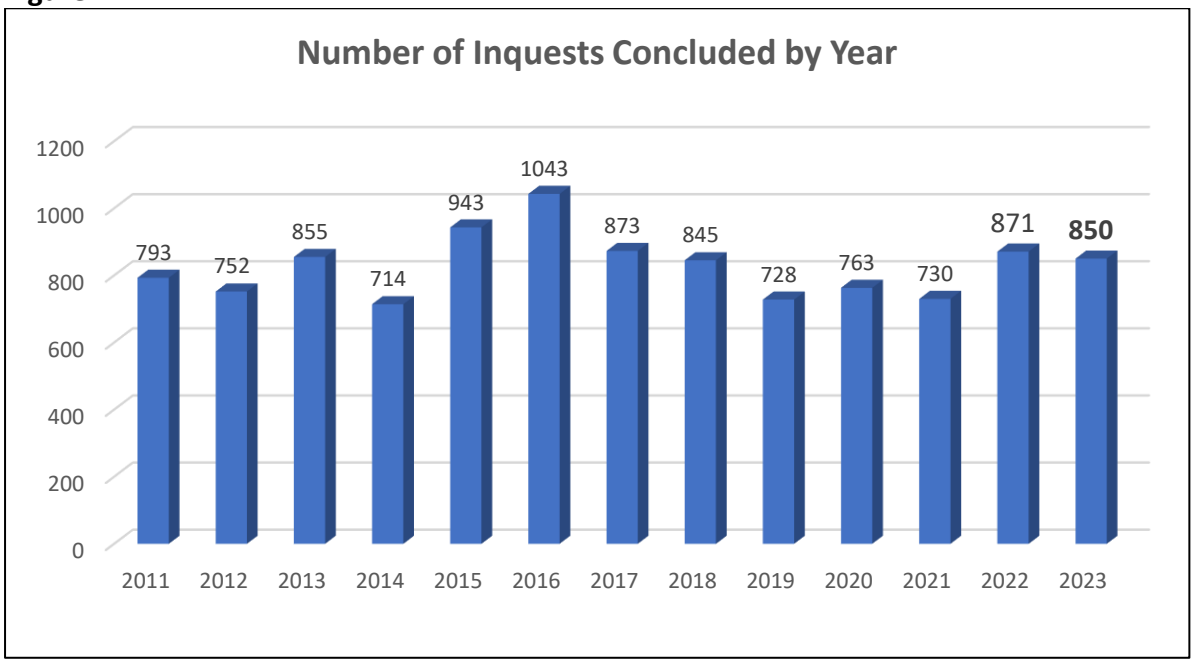
Figure 3 shows that post-mortem examinations as a percentage of the number of deaths reported in 2023 in Avon was 37% with the average (mean) for England and Wales being 44%.

Figure 3



In 2023 there were 850 inquests held in Avon as can be seen in Figure 4.

Figure 4



Of particular note, are the number of inquests opened as a percentage of deaths reported, this is 22%, the significance of this is that it is the highest since the figures started to be reviewed in 2006. (This can be seen in **Annex A**).

It is a requirement that Senior Coroners complete a notification each year to the Chief Coroner detailing those cases which have not been concluded within 12 months. At the time of writing this report the Chief Coroner has not requested these figures. Having reviewed the cases on the Civica case management system it is apparent that in Avon, there are approximately 44 cases over 12 months old up to 1st March 2024. A summary of the previous reports can be seen at **Figure 5**.

It is the Chief Coroner's view, that the reason for the continued high figures across England and Wales are multifactorial but include the residual effects of the pandemic; the chronic underfunding of the coroner service, the increase in the quantity and complexity of referrals and the ongoing shortage of pathologists. In addition to the external factors which are outside the coroner's control for example police prosecutions and specialist investigations by the Health and Safety Executive.

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**

6. Prevention of Future Deaths

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 act.

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

There were 8 prevention of future deaths reports written in 2023 which are detailed in **Annex B**.

7. Future Developments:

- The statutory medical examiner scheme commencing on 9th September 2024 will fundamentally change the way that deaths are processed. The impact on this is unknown at the time of writing this report, but there is no doubt that this change will be significant. It is anticipated that the simple cases where the death was due to natural causes will be managed by the medical examiner with the deceased's doctor, whereas

the referrals from the medical examiner into the Coroner's team will be more complex deaths requiring an investigation and inquest.

- The process for managing a death in the community, especially those out of hours, is also likely to be impacted with the introduction of the statutory medical examiner scheme. Again, the exact affect is unknown at the time of writing this report. This may impact on the number of cases referred and the process of referral.
- The ongoing management of a more complex caseload whilst maintaining standards. To achieve this there needs to be a sufficient and stable workforce with the provision of suitable court accommodation. These challenges are likely to continue for some time in Avon due to the volume of outstanding jury inquests and complex cases.
- Treasure will require the development of a system and case management process to ensure this work progresses efficiently and effectively.

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 another very busy year.

Thank you.

Maria Eileen Voisin

HM Senior Coroner

Annex A: Statistics from 2006 – 2023

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
2023	**3719**	**24**	**32**	**831**	**850**	**22%**	**19%**	**1383**	**37%**	**44%**
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 2023 (redacted copies)

There were 8 reports written in 2023 following the inquests of:

1. Gillan BAUMGARDT
2. Calogero DI BLASI
3. Andrew James REES
4. Gerald Roy CRUSE
5. Cherry Lynne GARLAND
6. Romeo Miles ESPOSITO
7. Madeleine Anna Gillian LAWRENCE
8. Alan Christopher NIPPARD

Redacted extracts from those reports appear below.

1. Gillan BAUMGARDT
Date of report: 28/02/2024
Report sent to: North Bristol Trust
Report by: Dr Simon Fox KC, Assistant Coroner

INVESTIGATION and INQUEST
On 20/12/22 an investigation was commenced into the death of Gillian Baumgardt. The investigation concluded at the end of the inquest on 27th February 2024. The conclusion of the inquest was –

"Mrs Baumgardt died in part because she underwent wrong site hip surgery due to multiple errors occurring in the performing and reporting of a plain x-ray of her hip".

CIRCUMSTANCES OF THE DEATH

Mrs Baumgardt was an elderly lady with dementia who fractured her right hip at home. She was admitted to your hospital and diagnosed correctly with a suspected fractured right hip.

However, in then performing and reporting the plain x-ray of her hips the following errors occurred – Radiographer –

- Pre-exposure marker not placed in film field;
- Digital image inadvertently flipped;
- Digital image mislabelled left/right so that fractured side recorded as left;
- Cross on image denoting flipped not detected;
- Normal x-ray of left hip did not alert to error and did not lead to the affected side being double checked; Radiologist –
- Normal x-ray of left hip attributed to error in labelling, rather than alerting to error and leading to the affected side being double checked.

As a result Mrs Baumgardt was referred to the orthopaedic team erroneously as presenting with a left hip fracture. Her age and dementia were such that she was difficult to assess clinically, the orthopaedic surgeons had no reason to suspect an error in labelling and she underwent surgery removing a healthy left femoral head.
The error was then appreciated and she had to undergo surgery to the right fractured hip 2 days later. She died 6 weeks later having never regained her mobility. I found on the evidence that the wrong site surgery contributed to her death.

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. –

(1)Accurate radiology is essential to avoid wrong site surgery in elderly patients with dementia suffering hip fracture;
(2) There is no system requiring radiographers to ensure that pre-exposure markers are present in the xray field in all such patients;
(3) There is no system requiring radiologists to investigate inconsistency in the site of injury between different images and to alert clinicians to the inconsistency before finalising their report in all such patients.

2. Calogero DI BLASI -
Date of report: 15/11/23
Report sent to: Secretary of State for Health; University Hospitals Bristol & Weston NHS Foundation Trust; XXXXXX, daughter of the Deceased; The Royal College of Physicians; Chief Coroner
Report by: Debbie Rookes, Assistant Coroner

INVESTIGATION and INQUEST

On 13th December 2022 an investigation was commenced into the death of Calogero Di Blasi. The investigation concluded at the end of the inquest on 15th November 2023. The conclusion of the inquest was:

The deceased died as a result of a recognised complication of an investigative medical procedure in circumstances where underlying cirrhosis and resultant varices were unknown, and not recognised as a possibility, by the Endoscopist

The cause of death was recorded as:

1a) Haemorrhagic shock

1b) Perforated gastric varix (post surgical procedure)

1c) Portal hypertension due to chronic alcoholic liver disease

CIRCUMSTANCES OF THE DEATH

On 10 August 2022, Calogero Di Blasi was referred by his GP to the Upper Gastrointestinal team at the Bristol Royal Infirmary for possible stomach cancer. He underwent an endoscopy on 18 August 2022 where biopsies were taken. The results showed abnormal cells. On 15 September, Mr Di Blasi was referred by a GP to the Lower Gastro-intestinal team for possible bowel cancer and had a CT scan on 4 November 2022. The CT scan revealed cirrhosis with portal hypertension and gastric varices, which were new incidental findings. The Lower GI team had been made aware of the investigations ongoing by the Upper GI team, but the upper GI team were unaware of the Lower GI team's involvement. Both referrals were made on the 2 week cancer referral pathway. The CT Scan was reported on 14 November, and double reported on 16 November 2022. However, the referring clinician did not review the report until the day after Mr Di Blasi's death, on 2 December 2022. The

incidental findings were not considered to be 'significant' by the Radiologists and were not therefore warrant an alert being sent to the referring clinician, leaving the report to be reviewed when they were able to. My investigation revealed that the timeframe for seeing patients on the cancer referral pathway is the date of the first appointment and there are no other target dates in respect of investigations of subsequent treatment.

Mr Di Blasi underwent a further endoscopy on 30 November 2022. The Endoscopist was unaware of these incidental findings. A biopsy was taken from an area which looked abnormal but was actually a gastric varix. As a result of this, Mr Di Blasi suffered a massive bleed and despite maximal supportive measures, he died on 1 December 2022 at the Bristol Royal Infirmary, Upper Maudlin Street, Bristol, BS2 8HW.

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. –

That one of the teams caring for Mr Di Blasi was completely unaware of the input from another specialty team, despite both referrals being made under the 2-week urgent referral pathway. The lack of communication between these teams meant that timely sharing of results did not occur. Even the very knowledge of the fact that a CT scan had taken place would have alerted the endoscopist to check those results, and it is likely that the second endoscopy would not have gone ahead. I understand this to be a national issue and is likely to apply to other investigations being carried out.

That the reporting timeframes on the 2-week urgent cancer pathway referral does not take into account timeframes for reporting investigative procedures or subsequent review by the referring clinicians.

The current training for Endoscopists for JAG certification requires the performance of 200 endoscopies. However, these tend to focus on the clinician's area of specialty and therefore there is a danger that lesion recognition will be limited and insufficient to ensure that endoscopists are able to recognise less frequently occurring lesions. With the need for an increasing number of endoscopists, action should be taken.

3. Andrew James REES

Date of report: 09/01/24
Report sent to: North Somerset Council (via their instructed solicitors, Clyde & Co); Boatfolk Marinas Ltd
Report by: Myfanwy Buckeridge, Assistant Coroner

INVESTIGATION and INQUEST

On 24th February 2023 an investigation was commenced into the death of Andrew James Rees. The investigation concluded at the end of the inquest on 9th January 2024. The conclusion of the inquest was: **Accident**

The Cause of death was recorded as:

1a) Immersion in water

CIRCUMSTANCES OF THE DEATH

Mr REES consumed very high levels of alcohol on a night out with friends on 3rd February 2023 which impaired his motor control when walking home severely intoxicated. His route home was alongside an unguarded part of Portishead Marina from which his body was later retrieved. He died at Portishead Marina Portishead North Somerset due to immersion in water

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. –

Boatfolk Marinas Ltd only

In evidence it was identified that, in the vicinity of where the deceased was retrieved from the water, the rescue chain on the wall of the marina was broken and that the system of visual inspection in place by Boatfolk Marinas Ltd had not identified this. Whilst a monthly, documented visual inspection has been introduced it is a concern that visual inspection alone may be insufficient to identify the risk of a deteriorating chain.

North Somerset Council only

During the course of evidence one of the triggers to generate a review of the Port Marine, Portishead Risk Assessment by North Somerset Council was stated to be a significant change of use but no formal assessment or measure of whether a change of use (e.g. increase in amount or type of footfall/increased cyclists etc.) had taken place was apparent.

4. Gerald Roy CRUSE

Date of report: 27th October 2023
Report sent to: Secretary of State for Health; Bristol Ambulance Emergency Medical Services; XXXX, Friend of the deceased; Royal United Hospitals Bath NHS Foundation Trust; South Western Ambulance Service NHS Foundation Trust; Chief Coroner
Report by: Debbie Rookes. Assistant Coroner

INVESTIGATION and INQUEST

On 12th December 2022 an investigation was commenced into the death of Gerald Roy Cruse. The investigation concluded at the end of the inquest on 27 November 2023. The conclusion of the inquest was:

Accident

The cause of death was recorded as:

1a) Pneumonia

1b) Rib fractures, haemopneumothorax

2) Osteoporosis, frailty, ischaemic heart disease, transient ischaemic attack

CIRCUMSTANCES OF THE DEATH

On 23 November 2022, Gerald Cruse was taken to the Royal United Hospitals Bath by ambulance following a fall at home. He was assessed as being suitable for the Ambulance Cohort Area, which was run by Bristol Ambulance Emergency Medical Services. Mr Cruse was placed in a bed once one became available. He needed to use the toilet so a member of ambulance staff lowered the bed rails and sat Mr Cruse on the edge of the bed before then going to get a wheelchair to transport him to the toilets. Mr Cruse then stood up and fell. He sustained a significant chest injury, including multiple rib fractures, a haemopneumothorax and surgical emphysema. He was cared for on a surgical ward in accordance with the admissions pathway, with input from the older persons medical team. Despite active treatment, his condition deteriorated and he developed pneumonia. Mr Cruse died on 7 December 2022at the Royal United Hospitals Bath.

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. –

Secretary of State for Health

-That over 75% of patients receiving hospital care are 65 and over. There is a conflict and tension between where within the hospital those patients should be receiving their care. A proportion of these patients require admission to a surgical ward due to the elements of their care which require surgical oversight and management, for example, analgesia through an epidural, insertion of a chest drain. However, this group of patients have multiple co-morbidities and complexities due to their age, which would be better managed by a medical team specialising in care of the elderly. Whilst medical teams can review patients, their limited resources mean it may not be as quickly as it needs to be, and they cannot be proactive in following up on the care of these patients. This results in an increasing risk that these patients will not receive the care they need in a timely manner. There is an increasing need for more doctors specialising in the care of older persons and this is a national issue.

-There are currently no clear guidelines as to how these patients should best be managed and there remains a serious risk that the care they receive is not holistic.

-Patients falling in hospitals and sustaining injuries which lead to their death remains a matter of grave concern.

Bristol Ambulance Emergency Medical Services

-The paramedic working within the cohort area did not complete a falls risk assessment in accordance with the JRCALC guidelines following the admission of a patient who had just had a fall at home.

-The other two ambulance staff did not seem to understand that Mr Cruse was a falls risk, they did not consider that he was at a greater risk of falls and did not consider that any further action should have been considered or taken.

-An investigation took place but the staff did not identify any learning and did not undertake the case study to help them identify such patients in the future. Bristol Ambulance Emergency

Medical Services still run some cohort areas alongside South Western Ambulance NHS Foundation Trust, and continue to convey patients to hospital. The evidence given on behalf of this organisation did not provide reassurance that this is a matter which the ambulance service have adequately addressed. There is a real concern that ambulance staff throughout the organisation may not be adequately trained in recognising and dealing with patients who have had a fall or falls.

5. **Cherry Lynne GARLAND**
Date of report: 08/09/2022
Report sent to: Chief Executive, University Hospitals Bristol and Weston NHS Foundation Trust ('UHBW')
Report by: Robert Sowersby, Assistant Coroner

INVESTIGATION and INQUEST

On 31 October 2022 an investigation commenced into the death of Ms Cherry Lynne GARLAND, aged 77. The investigation concluded, at the end of a 2-day inquest, on 17 August 2023.

The medical cause of death was:

1a) Sepsis and Right sided heart failure

1b) Coronary artery atheroma (operated)

2) Chronic Lymphocytic leukaemia

The narrative conclusion of the inquest was as follows:

Cherry Garland was 74 years old and had a background of known heart problems and Chronic Lymphocytic Leukaemia when she underwent a percutaneous procedure to examine and stent her coronary arteries. Unfortunately one of her arteries perforated during the procedure and she required emergency open-heart surgery. The surgery was successful, but she suffered vascular injury from the presence of an arterial sheath, and went on to develop Covid. She then developed pneumonia, which in turn triggered sepsis, and sadly she died on 11 October 2022, in the Bristol Royal Infirmary, as result of both sepsis and right-sided heart failure.

CIRCUMSTANCES OF THE DEATH

It is not necessary to give more detail about the circumstances of death in this case, because the issue I am addressing in this report did not contribute to Ms GARLAND's death – it was 'incidental' to her death, but still extremely important.

CORONER'S CONCERNS

During the course of the inquest the evidence revealed matters giving rise to concern as follows –

Background

I heard evidence that when Ms GARLAND was on the Cardiac High Dependency Unit 'HDU' (part of the Intensive Care Unit) she was receiving intravenous antibiotics
When she then transferred from HDU to the Cardiac Ward there was a transcription error, and these antibiotics were accidentally omitted from the list of medications that she should be given on the new ward
As a result Ms GARLAND's antibiotics were discontinued accidentally

I heard (and accepted) evidence that it would have been reasonable to discontinue antibiotics in any event at the time of Ms GARLAND's transfer
Notwithstanding that fact, I remain deeply concerned by the circumstances in which the error took place

My concerns

- I heard evidence from an ICU Consultant (who I found to be both a reliable and an impressive witness), who told me, among other things, that:
  - "*… Transcription errors have always been a problem…*" the ideal way to get rid of them would be to have a system [in the rest of the hospital] that speaks to ours
  - The ICU retains lists of its patients' medication on a computerised/electronic system
  - The rest of the wards in the hospital do not operate the same system
  - The available systems do not speak to each other (to put it in somewhat colloquial terms)
  - Efforts to address that problem have proved fruitless
  - As a result, every time an inpatient moves from ICU to another department in the hospital, an appropriately qualified member of staff has to physically transcribe that patient's medication list
  - With (for instance) 10 patients moving per day, 15-20 medications per patient, and multiple elements for each medication (name; dose; timing; indication; start date; signature etc.), "*at a conservative estimate 1,500 to 2,000 elements [are transcribed] daily*"
    (Coroner's comment: for obvious reasons this creates enormous potential for human error)

There are a limited number of people who can prescribe (and are therefore able to perform this task); in critical care they are the same people who are responsible for providing care

- "*We really need a second check… funding for more pharmacists… as a Trust we've fallen short of ICU national standards for years in terms of the number of pharmacists per bed and medicines reconciliation*"
- "*I spoke to the Chief Pharmaceutical Officer – he has submitted 5 proposals in the last 7 years to try to get the deficit funded…* [without success]"

In summary, my view is that the circumstances currently in place create a very real (and known) risk that transcription errors will continue to occur. This in turn endangers patients, and creates a risk that people will die in the future as a result of such errors.

It is, sadly, very easy to envisage circumstances in which a patient might not receive essential medication at all, might receive the wrong dose of the medication they need, or might receive the wrong medication altogether, because of a transcription error.

In my opinion there is a risk that future deaths will occur unless action is taken, and in the circumstances it is my statutory duty to report to you.

6. Romeo Miles ESPOSITO
Date of report: 15/03/24
Report sent to: South Western Ambulance Service Trust
Report by: Dr Simon Fox KC, Assistant Coroner

INVESTIGATION and INQUEST
I held an Inquest in the death of **Romeo Miles Esposito** on 14-15th March 2024. The conclusion of the inquest was –

Romeo was found unconscious in bed at home. Emergency staff attended but stopped resuscitation and assessed Romeo as having died. This proved incorrect – he continued to make respiratory effort

and his heart beat returned for some time before resuscitation resumed. However, he died in hospital the next day from a brain injury consequent upon his cardiac arrest.

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. –

(1) Romeo was making respiratory effort for about an hour after ROLE at 0952 hours and resuscitation being resumed at 1049 hours;
(2) His family raised their concerns regarding this with SWAS clinical staff on a number of occasions throughout this period;
(3) Staff repeatedly ascribed the respiratory effort to *"a release of air*", as opposed to a change in Romeo's clinical condition which required further clinical assessment;

There was no evidence to confirm that clinical staff have been warned or trained not to use *"a release of air"* as an explanation for respiratory effort or a reason to avoid further clinical assessment.

7. Madeleine Anna Gillian LAWRENCE:

Date of report: 06/11/23
Report sent to: Care Quality Commission; XXXX, parents of the Deceased; North Bristol NHS Trust; Chief Coroner
Report by: Dr Peter Harrowing, Area Coroner

INVESTIGATION and INQUEST

On 31st March 2022 I commenced an investigation into the death of Ms. Madeleine

Lawrence age 20 years. The investigation concluded at the end of the inquest on 8th September 2023. The conclusion was that the medical cause of death was I(a) Multi organ failure; I(b) Group A Streptococcal sepsis; I(c) Streptococcal necrotising myositis; II Traumatic native hip dislocation and the narrative conclusion was

'Madeleine Laurence died of a rare complication of an infection which developed after she suffered an injury whilst playing rugby. In hospital her deterioration was not recognised and necessary life-saving treatment was not commenced promptly.

Madeleine's death being contributed to by neglect.'

CIRCUMSTANCES OF THE DEATH

On 9th March 2022 Ms. Lawrence was playing rugby when she suffered a traumatic native hip dislocation following a tackle. She was taken by ambulance to Southmead Hospital, Bristol where underwent reduction of the dislocation under general anaesthesia. The following day she developed pain in her hip and overnight from 10th to 11th March 2022 her condition deteriorated.

Observations were not performed for several hours and when undertaken confirmed her NEWS score of 4. The frequency of the observations were not increased and the provisions of NEWS toolkit and the SEPSIS6 protocol were not followed. The NEWS score later increased to 5 and again observations were not carried in a timely manner and prompt treatment for presumed sepsis was not initiated.

When Ms. Lawrence was reviewed on Monday 14th March 2022 it was recognised that she was seriously unwell and she was immediately transferred to the Intensive Therapy Unit. She was treated for sepsis and underwent a number of surgical procedures. Ms. Lawrence was diagnosed with necrotising myositis but despite all efforts her condition deteriorated and she died in hospital on 25th March 2022.

During the course of my investigation I became aware that the NHS Trust had taken steps to increase awareness and training in the NEWS toolkit and the recognition and treatment of the deteriorating patient and sepsis in particular. The focus of the Trust's efforts had been the ward where Ms. Lawrence was accommodated but that training across the wider Trust was ongoing.

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. –

(1) That serious deficiencies affecting the safety of patients at Southmead Hospital, Bristol which had been identified following the death of Ms. Lawrence

The CQC should confirm that it is now satisfied that the Trust has addressed the training of current staff and has in place appropriate measures to ensure ongoing training for new staff.

8. Alan Christopher NIPPARD
Date of report: 24th July 2023
Report sent to: Royal United Hospital
Report by: Maria Voisin, Senior Coroner

INVESTIGATION and INQUEST

On 7 July 2022 I commenced an investigation into the death of Alan

Christopher NIPPARD. The investigation concluded at the end of the inquest. The conclusion of the inquest was a narrative including a finding of neglect.

Mr Nippard's death was caused by a pressure sore. The pressure sore was preventable with the provision of basic nursing care, this was not provided. There was a gross failure to provide basic nursing care. Once he had the pressure sore his death could have been prevented with the provision of basic nursing care, such as, skin care, regular re-positioning and personal care, this was not achieved at all. He was not managed in line with recognised nursing practice and as a consequence his death was contributed to by neglect.

The medical cause of death was recorded as:

1a Sepsis

1b Necrotising fasciitis/Fournier s gangrene

1c Pressure sore sacrum

II Septic arthritis, Type 2 diabetes mellitus, chronic kidney disease, left ventricular systolic dysfunction

Circumstances of the death

According to Mr Nippard's GP, Mr Nippard had a medical history which included poorly controlled type 2 diabetes, peripheral vascular disease, ischemic heart disease and chronic kidney disease stage 4. He had also undergone amputations of his toes due to non-healing diabetic ulcers.

His daughter, said in evidence that he was admitted to hospital on 30th May 2022 following a fall at home. He said that he'd fallen forward and onto his knee. He was lifted from the floor and onto his bed by his family where he remained until an ambulance was called, when the decision was taken to admit him to the Royal United Hosptial (the RUH) in Bath.

He was admitted via the Emergency department, then to the medical assessment unit (MAU), and then onto the Orthopaedic ward – Pierce Ward on 1st June 2022 in the early hours.

According to the Consultant Orthopaedic Surgeon, Mr Nippard was initially admitted, with the diagnosis of right knee septic arthritis and an acute kidney injury on top of his chronic kidney disease. Mr Nippard was on antibiotics and on 2nd June 2022 underwent a washout of his knee. On 8th June he had a second washout. By 17th June he was deteriorating, on 20th June his CRP was increasing. He said in his evidence that the pressure sore was first documented by the orthopaedic team on 21st June, the surgeon described this now as - the bigger source of infection**.**

An MRI was requested but did not take place for 4 days; it was undertaken on 25th June and reported as showing no obvious sacral osteomyelitis it did show that it had locally spread in the soft tissue.

By 28th June Mr Nippard was getting worse, his inflammatory markers were going up and now his testicles were swollen, and there was a suspicion was that this was Fournier's Gangrene and there was a referral made to the Urology team.

The orthopaedic surgeon said that as far as the treatment for Mr Nippard's knee went, he felt they were winning that it was improving that if he hadn't developed the pressure sore his expectation was that he would have been discharged. He agreed with the medical cause of death proposed.

A Consultant Urologist examined Mr Nippard on 28th June, he said that he had evidence of a significant infection, that the only treatment was surgery, and all agreed that surgery was not likely to help, and it would cause Mr Nippard immense suffering in his last days. He explained that the other medical conditions Mr Nippard suffered with caused him to be compromised, if he'd had a stronger heart and kidneys then they would have operated

Sadly, after discussions with Urologists, Surgeons, Anesthetists and the Critical care team it was decided that Mr Nippard was not fit for surgery, and he was placed on priorities of care and died on 6th July 2022. It was the view of the doctors who attended the inquest and gave evidence that the pressure sore significantly contributed to Mr Nippard's death.

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 heard from the Trust's Lead Tissue Viability Nurse, she had reviewed the notes and provided her opinion on what did happen, and what should have happened, in relation to the nursing care he was provided with.

There were many concerns that she raised, she said in summary the pressure sore was preventable, that it's basic nursing care and this wasn't achieved. That once it had developed, if he'd had good skin care and the SSKIN bundle had been followed the damage would have been minimized. When asked how bad the care was she said - it was shocking.

It was accepted that Mr Nippard did not have a sacral pressure sore when he was admitted to the RUH and that it was deemed hospital acquired.

That the first time that the sacral pressure sore was mentioned in the notes was on 2nd June 2022 when a Tissue Viability Nurse (TVN) referral was sent, stating - for suspected deep tissue injuries to buttocks with blistering, stating the area appeared overnight.

I was told that there were a number of areas of concern with regard to the risk assessment, management and care and treatment that Mr Nippard received including:

- That the screening tool completed on 31st May scored Mr Nippard as, not at risk of a pressure sore – this was wrong; he was at risk due to his immobility and diabetes which increased the risk of a pressure sore developing, in addition to his age and his medical history. He should have been scored high risk. Because of this - nothing happened and it should have. Mr Nippard should have been on an air mattress and he should have been re-positioned regularly.
- On the MAU he did not have his risk assessment done within 6 hrs as it should have been.
- It is recorded that he was on an air mattress on Pierce ward on 1st June but the time of this is unknown. This meant he probably went up to 2 days after his admission without an air mattress.
- Mr Nippard's risk assessment was not carried out until 2 days post admission, (1st June) it did record his risk as high, this is a significant delay.
- Once recorded as high risk Mr Nippard should have been reassessed every week – this was not achieved.
- The SSKIN bundle, a nationally recognised tool with care plan was rarely completed and when it was it was poorly completed.

Skin assessments should have been carried out daily, when they were carried out were ad hoc and inaccurate, sometimes skin was recorded as

normal when it clearly wasn't.

- On one occasion a body map was circled indicating the areas of concerns – sacrum and left heel but lacked information and categorisation
- Of significant concern is the fact that Mr Nippard spent long periods of time on his back with little or no evidence of offloading of the sacrum or heels at all. He should have been repositioned every 2-3 hours during the day and between 2-4 hours at night. There was no structured re-positioning at all.
- It was estimated that every day he was in hospital he was on his back for 22 ½ hours and there was no sustained time off his sacrum and there should have been.
- When he was sat in his chair there is no evidence that he had an air cushion to sit on and when sat, he should have been stood hourly.
- It was raised that there was a query of his own compliance but there is only 2 occasions on 6th and 20th June when he declined to be moved There was no evidence of the use of 2 sliding sheets to assist with moving him.

- On 11th June it was a podiatrist who raised the new pressure sore on the right heel and completed an incident report – this should have been managed and picked up by the nurses in their daily checks. In addition he should have had repose boots to prevent this and there is no evidence they were used at all.
- Mr Nippard had a catheter and incontinence – he should have been checked regularly, offered the toilet, the commode, bed pans should have been a last resort. She could not see this was achieved at all. The fact Mr Nippard was left to soil the bed was not acceptable care and that the limited personal care described by the family was not acceptable.
- Fluid balance charts were poorly completed.
- He wasn't weighed which would have assisted with managing his oedema.
- Appropriate nursing care was not achieved and pressure care was a fundamental part of nursing care.

I have been advised that The Trust have taken significant steps since Mr Nippard's admission, however, I have not been reassured by those involved with Pierce Ward that this will not happen again. Specifically, I have been advised by The Lead Tissue Viability Nurse that she has ongoing concerns and indeed The Interim Deputy Divisional Director of Nursing for Surgery and The Divisional Director of Surgery have confirmed that there have been two pressure sore incidents on Pierce Ward this month (July 2023). I have been told that the reason for this could be the need for training of staff on Pierce Ward on : risk assessment, prevention care and treatment of pressure sores by the tissue viability team.