M. E. Voisin
Her Majesty's Senior Coroner
Area of Avon

17th June 2022 REF: 16192

	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO: Air Balloon Surgery** **Cc to Care Quality Commission.**
1	**CORONER** I am Dr Simon Fox QC Assistant Coroner for **Area of Avon.**
2	**CORONER'S LEGAL POWERS** I make this report under paragraph 7, Schedule 5, of the Coroners and Justice Act 2009 and regulations 28 and 29 of the Coroners (Investigations) Regulations 2013. http://www.legislation.gov.uk/ukpga/2009/25/schedule/5/paragraph/7 http://www.legislation.gov.uk/uksi/2013/1629/part/7/made
3	**INVESTIGATION and INQUEST** On 08/04/2020 I commenced an investigation into the death of Donald Gore. The investigation concluded at the end of the inquest on 17/6/22 . The conclusion of the inquest was – **Natural Causes contributed to by neglect.**
4	**CIRCUMSTANCES OF THE DEATH** Mr Gore acquired Mycobacterium Chimaera infection from the aerosol produced by a Liva Nova heater cooler unit used in association with a heart bypass machine during open heart surgery at Bristol Royal Infirmary on 16th November 2016. Mr Gore presented with symptoms of Mycobacterium Chimaera infection from November 2017 – 12 months after the operation at which he contracted it. There was a delay in diagnosis of the infection until just 3 weeks before his death 21 months later, during which time he was assessed by numerous clinical staff in both primary care and in hospital and as both an inpatient and outpatient. The reason for the delay in diagnosis was that Mr Gore did not receive appropriate medical management in the following respects – a) In March 2017 the cardiac surgery department did not send Mr Gore the standard letter to patients advising him of the risk of Mycobacterium Chimaera infection; b) In November 2017 the General Practitioner to whom he first presented with symptoms did not read the alert regarding the risk of Mycobacterium Chimaera infection contained in his GP records, entered in March 2017 further to a letter sent to the practice by the cardiac surgery department, or advise hospital doctors of his risk of Mycobacterium Chimaera

	infection; c) Hospital doctors, in particular in infectious diseases/microbiology and cardiology, who saw Mr Gore on numerous occasions from November 2017 onwards were unaware of the risk (from their own knowledge or from Mr Gore's hospital records) or did not recognise the risk of Mycobacterium Chimaera infection and did not test for it until July 2019 – 4 weeks before he died; d) When requests were eventually made for tests on cerebrospinal fluid or blood cultures for Mycobacterium Chimaera infection, these were not acted upon or were delayed. During the delay Mr Gore was misdiagnosed with sarcoidosis, as a result of which he was treated with long term steroids which may have accelerated his Mycobacterium Chimaera infection or made it more severe.
5	**CORONER'S CONCERNS** During the course of the inquest the evidence revealed matters giving rise to concern. In my opinion there is a risk that future deaths will occur unless action is taken. In the circumstances it is my statutory duty to report to you. The **MATTERS OF CONCERN** are as follows. – The evidence demonstrated that the General Practitioner to whom Mr Gore first presented with symptoms on 3.11.17 did not read the alert regarding the risk of Mycobacterium Chimaera infection contained in his GP records, entered in March 2017 further to a letter sent to the practice by the cardiac surgery department. The investigation in response to this is summarised in a document headed *"Proforma for completion at SEA/adverse incident meeting"* dated 14.11.9. My concerns are - 1. The investigation in response to this incident summarised in that document – a) Does not conform to the usual detail and format of such investigations (eg a Root Cause Analysis), and b) Appeared inadequate; (In addition the investigation and document, or even their existence, were not disclosed to the Coroner's office despite three GP statements/reports from your practice being requested and provided in the preparation for the Inquest, only being revealed in the course of oral evidence from the GP during the course of the Inquest).

6	**ACTION SHOULD BE TAKEN** In my opinion action should be taken to prevent future deaths and I believe you have the power to take such action.
7	**YOUR RESPONSE** You are under a duty to respond to this report within 56 days of the date of this report, namely by 15.8.22. I, the coroner, may extend the period. Your response must contain details of action taken or proposed to be taken, setting out the timetable for action. Otherwise you must explain why no action is proposed.
8	**COPIES and PUBLICATION** I have sent a copy of my report to the chief coroner and to the following interested persons [redacted], North Bristol Trust, University Hospitals Bristol &Weston, Public Health England, Dr [redacted] I have also sent it to the CQC who may find it useful or of interest. I am also under a duty to send the chief coroner a copy of your response. The chief coroner may publish either or both in a complete or redacted or summary form. He may send a copy of this report to any person who he believes may find it useful or of interest. You may make representations to me, the coroner, at the time of your response, about the release or the publication of your response by the chief coroner.
9	17/06/2022 Simon Fox Signature Dr Simon Fox Assistant Coroner **Area of Avon**

[redacted]
[redacted]
The Coroner's Court, Old Weston Road, Flax Bourton, BS48 1UL