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

8 September 2023 [redacted]

	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO:** **Chief Executive, University Hospitals Bristol and Weston NHS Foundation Trust ('UHBW')**
1	**CORONER** I am Robert Sowersby, Assistant Coroner for the **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 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.*

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4	**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.
5	**<u>CORONER'S CONCERNS</u>** During the course of the inquest the evidence revealed matters giving rise to concern as follows – <u>Background</u> • 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 <u>My concerns</u> • 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	**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 3 October 2023. 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 family of the deceased. I have also sent it to the Care Quality Commission 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	08/09/2022 Signature  Robert Sowersby Assistant Coroner **Area of Avon**

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