Falls and avoidable deaths in hospital: when should the Coroner sit with a jury?

EDWARD RAMSAY, BARRISTER, 12 KING’S BENCH WALK

Inquest juries – the background

The significant legislative changes to the coronial system are now three years old. Even before their implementation in 2013 the impact of Article 2 of the European Convention on Human Rights had left its mark. One cannot be left in any doubt that the Coroner’s court is not what it used to be. As was observed by Moses LJ 10 years ago in R (Lin) v Secretary of State for Transport [2006] EWHC 2575 (Admin) [at 32]:

“Long gone are the days of travel to some dispiriting corner of St Pancras or Battersea only to be told peremptorily, when appearing on behalf of the bereaved, “Keep quiet and sit down.” Coroners nowadays are more concerned to conduct full inquiries with ample opportunity for participation, even absent the obligation to conduct enhanced inquests. Many, I was told, seek to conduct a full and fair inquiry and do not believe in offering the bereaved what may be perceived as a second-class inquest. Thus, following Taskoushis, there will often be little difference in practice between an enhanced Middleton—type inquest and other inquests following deaths which give rise to concern both to those immediately involved and to their families”.

With these changes in mind it is something of an anomaly that the Coroners and Justice Act 2009, which sought not only to put bereaved families at the very heart of the coronial reforms but also converted the power to report (under old Rule 43 of the Coroner Rules 1984) into a statutory duty to do so (under the new Regulation 28 of the Coroners (Investigations) Regulations 2013), also removed the obligation on the coroner to summon a jury of between 12 and 23 individuals; 12 would be required to deliver a verdict. The Coroners Act 1887 placed a requirement upon the Coroner to summon a jury of between 12 and 23 individuals; 12 would be required to deliver a verdict. The Coroners (Amendment) Act 1926 reduced the number of jurors to between 7 and 11. At the same time the 1926 Act began the process of whittling down the number of occasions when a jury would be required. The principles set out in the 1926 Act were later enshrined in the Coroners Act 1988. The 2009 Act is responsible for a further tightening.

Hospital cases

With the removal of the old Section 8(3)(d) of the 1988 Act, what provisions are left? And when do they apply in cases of deaths in hospital?

It must not be forgotten that the concern to conduct a full inquiry should in every case include careful consideration as to whether the Coroner should sit with a jury. The relevant provisions of the CJA 2009 are found in Section 7.

In hospital cases there are usually two categories of case when a jury will be mandated. One is well-recognised, namely when the deceased was in state detention and the cause of death is unnatural or unknown (s.7(2)(a) CJA 2009). These cases usually relate to Section 2 and Section 3 Mental Health Act 1983 patients; or those subject to a Deprivation of Liberty Safeguard (DoLS) under the Mental Capacity Act 2005.

The other less well-known category is where the Coroner has ‘reason to suspect’ that the death resulted from a notifiable accident (notifiable in this case to the Health

continued on page 16
and Safety Executive (HSE) pursuant to the Reporting of Injuries, Diseases and Dangerous Occurrences Regulations 2013, ‘RIDDOR’ (s.7(2)(c); s.7(4) CJA 2009).

Reason to suspect is a low threshold. It does not require positive proof. It is the same standard of proof required of the Coroner in initiating an investigation into death under Section 1 of the 2009 Act.

The third remaining category of case is where the Coroner has a residual discretion to sit with a jury where there is ‘sufficient reason’ for doing so (s.7(3) CJA 2009).

As to this last category it is often assumed that in hospital death cases (where the medical and expert evidence may be complex) the jury will be unable to cope (see for instance the transcript of the discussion in Bloom v HM Senior Coroner for the Western District of London [2014] EWHC 2698 (Admin). And that is even before considerations around listing and the additional expense of jury cases are factored-in. There is an ever present danger that the former is used as a fig leaf for the latter.

It is the second and third categories which are now discussed by reference to hospital falls and other avoidable deaths.

Hospital falls

The figures are staggering. There are, according to NHS England, over 250,000 inpatient falls in acute and community hospitals and mental health units in England reported each year.

NHS England is clear as to the scale and complexity of the problem.

“Falls prevention is a complex issue crossing the boundaries of health and social care, public health and accident prevention....

Falls are a major concern for patient safety and a marker of care quality. A significant number of falls result in death or severe or moderate injury, at an estimated cost of £15 million per annum for immediate healthcare treatment alone (NPSA, 2007)”

Anyone with any experience of inquests will know that a significant number of hospital deaths reported to the coroner are directly or indirectly attributable to an earlier inpatient fall.

Many of the falls cases reported to the Coroner will already have been investigated internally (with varying quality) by way of a Serious Untoward Incident Report (SUI) or Root Cause Analysis Report (RCA).

In many instances the SUI or RCA will have identified shortcomings and failures in, for example, nursing supervision, inappropriate use of bedrails, lack of risk assessment and care planning documentation, and deficiencies in training and staff awareness. In other cases, similar failures will be obvious or suspected from review of the medical records and contemporaneous documents (or lack of them).

Consider the following example: an elderly patient with dementia is admitted to hospital as a result of a fall at home. He has a fracture to his clavicle. On admission to a general gerontology ward a risk assessment puts him at high risk of falls and a high cot-side risk; but no falls care plan is initially completed. The patient is nursed in a cohorted bay with 4 other patients all at high risk of falls. The patient sustains a fall whilst getting out of bed in the early hours of the morning. There is some evidence the patient was trying to get to the toilet and had not been taken to the toilet for a number of hours. There are question marks about the levels of nursing care and supervision that morning. The cot sides were up when they should have been down. The patient injures his head and arm in the fall, sustaining fractures to both. There is a dispute as to whether the cot-sides had been negotiated or were instrumental in the severity of the injuries sustained. He is later discharged back to the care of a nursing home with a fracture to the humerus which has, by this stage, migrated through the skin and is covered with no more than a plastic stoma bag. The patient dies shortly after admission to the home. The fall is not reported internally at the Trust as having caused or contributed to the patient’s death. The death is not reported by the Trust to the Coroner but by the care home GP who refuses to sign the death certificate and makes an Adult Safeguarding Referral. There is a police investigation which is subsequently discontinued. An internal investigation by the Trust is later conceded to have been unsatisfactory.

Many practitioners will have dealt with similar cases. This was a real case heard in Coventry this year in which the author represented the family. The Trust resisted the suggestion that the matter was or would have been reportable under RIDDOR thereby mandating the need for the Coroner to sit with a jury. The Coroner consulted the HSE and added them as a Properly Interested Person. The point was eventually conceded. A jury was sworn. A narrative conclusion was returned with a rider of neglect.

16 Articles: Falls and avoidable deaths in hospital: when should the Coroner sit with a jury?

continued from page 15

1&2 www.england.nhs.uk/patientsafety/falls-prevention
In any hospital fall case where the patient has subsequently died it is necessary to consider whether there is a suspicion that the death was caused or contributed to as a result of a fall that is suspected to also have been reportable under RIDDOR.

In October 2014 the HSE issued Health Services Information Sheet No.1 (Revision 3) titled “Reporting injuries, diseases and dangerous occurrences in health and social care”. Reportable accidents (including falls) involving patients will include those that:

• arise out of or in connection with a work activity (including nursing care and supervision); and
• result in death; or
• a specified injury (including fractures, other than to fingers, thumbs and toes; amputations; any injury likely to lead to permanent loss of sight or reduction in sight; any crush injury to the head or torso causing damage to the brain or internal organs; serious burns (including scalding) which: cover more than 10% of the body; or cause significant damage to the eyes, respiratory system or other vital organs; any scalping requiring hospital treatment; any loss of consciousness caused by a head injury or asphyxia; any other injury arising from working in an enclosed space which: leads to hypothermia or heat-induced illness; or requires resuscitation or admittance to hospital for more than 24 hours).

Importantly the HSE acknowledged “in the past, there has been some misunderstanding as to the range of accidents that should be reported under RIDDOR when they involve members of the public who are patients, residents, service users or visitors. The following examples will help you decide about reportability”. Reportable falls would include the following:

**Example 1**

A service user (who is capable of understanding and following advice) falls off the toilet, having previously been advised not to get up, is injured and taken to hospital. They have been left alone for dignity reasons. Their care plan identified that the individual should have assistance or supervision.

**Reportable**

The member of staff left the service user out of earshot and without a call bell they could use, or had not responded promptly when they did call, as adequate supervision had not been provided.

**Not reportable**

The member of staff returned to help them as soon as they called to say they have finished. Or if the service user had got up without calling for help, it would not be reportable.

**Example 2**

An incontinent service user slips on their own urine when returning back from the toilet and receives a major injury.

**Reportable if:**

• the assessment had identified the resident needed help for toileting and it was not provided;
• the fall took place in an area of the home where it was foreseeable the resident may slip due to a spillage and the home had failed to assess risks from floor surfaces or act on their assessment.

**Example 3**

A patient falls from a stretcher while being manoeuvred into an ambulance and suffers a hip fracture.

**Reportable if:**

• the paramedics had chosen the wrong piece of equipment to move the patient, or had not received the appropriate training about safe use of the equipment, or were not following a safe system of work;
• the paramedics were aware the patient had a history of aggression and failed to take this into account when moving them. The patient subsequently becomes aggressive and falls from the stretcher.

**Not reportable if:**

• the patient became unexpectedly aggressive, struggled and fell.

You may need to consult the patient’s/service user’s care plan to decide what care was assessed as being appropriate for them. If you still are unclear, ask for advice.

The Coroner need only form a suspicion that the fall was reportable (and that the death was caused or contributed to by the fall) before the requirement for a jury is triggered. What this means in practice is that if any case falls within or near one of the examples given by the HSE in the 2014 Information Sheet then it follows that the inquest must

---

3 [www.hse.gov.uk/pubns/hsis1.htm](http://www.hse.gov.uk/pubns/hsis1.htm)
be held with a jury. In every falls case the Coroner will need to be shown a copy of the Information Sheet at a Pre-Inquest Hearing if the matter has not already been reported to the HSE by the Trust. Whether the matter has in fact been reported to the HSE is irrelevant to the application of Section 7(2)(c) of the CJA 2009.

Avoidable deaths

Avoidable deaths are by definition unnatural deaths and fall to be reported to and investigated by the Coroner under Section 1 of the CJA 2009.

In hospital cases where the deceased was not in state detention or where the Coroner has no reason to suspect that the death arose from a notifiable accident reportable under RIDDOR (see above), what is the scope for requesting that the Coroner nevertheless sit with a jury?

In *Shafi v HM Coroner for East London [2015] EWHC 2106 (Admin)* a checklist of factors were said to be relevant in each case to the Coroner’s discretion under Section 7(3) of the CJA 2009. These include amongst others “whether the facts of the case bear any resemblance to the types of situation covered by the mandatory provisions” (as was set out at [45] in *R (Paul) v Deputy Coroner of the Queen’s Household [2008] QB 172*).

The Care Quality Commission (CQC), just like the HSE, is a Non-Departmental Public Body (NDPB). Under Regulation 16 of the Care Quality Commission (Registration) Regulations 2009 hospitals are required to notify the CQC where there is a death of a service user unless the death “cannot, in the reasonable opinion of the registered person [the hospital], be attributed to the course which that service user’s illness or medical condition would naturally have taken if that service user was receiving appropriate care or treatment” – in other words an unnatural death.

The definition of an unnatural death is one that is both unexpected and the result of culpable human failure (*R (Touche) v HM Coroner for Inner North London [2001] QB 1206* at [46]).

Reports to the CQC under Regulation 16 do not engage Section 7(2)(c) of the 2009 Act. The reason is that the CQC is not an inspector appointed under the Health and Safety at Work Act 1974 (s.7(4)(c) CJA 2009).

But that is about the only difference. It follows the Coroner need only have ‘reason to suspect’ that the death was reportable under Regulation 16 of the Registration Regulations in order for a notification thereunder to effectively resemble a notifiable accident reportable under RIDDOR. In those circumstances it would be a powerful reason, absent any other views expressed to the contrary, for the Coroner to exercise the discretion to sit with a jury.

The importance of Regulation 16 in the context of hospital inquests cannot be overstated. The Coroner’s duty to investigate under Section 1 of the CJA 2009 is triggered only where he has ‘reason to suspect’ that the death was unnatural, or the cause of death is unknown, or the deceased died in state detention. In many, if not most hospital cases, the central issue is whether the death was unnatural. It follows that it is not open to the hospital trust to argue in such a case that Regulation 16 is irrelevant. If it were the Coroner would have already discontinued the investigation (under *Section 4 of the CJA 2009*). For the purposes of persuading the Coroner that a jury is required the ‘reasonable opinion’ of the hospital under Regulation 16 is immaterial. What matters is the Coroner’s opinion. And, by definition, his opinion must already be one of suspicion.

Conclusion

Before 1926 all inquests were held with a jury. Since then Parliament has made significant inroads into the use of jury inquests. Section 8(3)(d) of the 1988 Act did not survive the 2009 Act, which in other respects brought about a significant strengthening of the ability of the coroner to conduct a full inquiry with the assistance of the family. But the role of the jury is an important one and is mandated in the most serious and high profile cases. These include deaths suspected to have been reportable to the HSE under RIDDOR. The examples given by the HSE are very wide-ranging and it is difficult to see an investigation in a patient hospital fall case falling totally outside the HSE guidance as reportable. The threshold for the Coroner (reason to suspect) applies, by definition, a lower standard of proof than the HSE’s own guidance. There is a good case for suggesting that in every inquest into a hospital death (where the main issue is the unnaturalness of the death) the Coroner should be looking closely at the discretion to sit with a jury because the suspicion that the death was avoidable (and therefore reportable to the CQC) will already have arisen.

Edward Ramsay is a Barrister at 12 King’s Bench Walk specialising in hospital inquests
An inquest touching the death of SP was heard on 1st September 2016 at Cardiff Coroner’s Court.

**Issues:** elderly care; biliary obstruction; delay in obtaining CT results due to remote radiology arrangements; Delay resulting in lost opportunities to undergo treatment.

**Background**

SP developed symptoms and signs of biliary obstruction early in 2015 at the age of 71. She was reviewed initially by physicians at the Royal Gwent Hospital who referred her to the specialist liver unit at the University Hospital of Wales (UHW). In March 2015 she was diagnosed with cholangiocarcinoma.

SP was readmitted to the Royal Gwent hospital on 7/5/15 and again on 18/5/15 with recurrent biliary sepsis. SP responded well to intravenous antibiotic therapy and underwent ERCP and stenting. Her pre-operative work up for the liver resection was also being done at this time.

SP had a past medical history which included obesity, antiphospholipid syndrome (IVC filter in situ and on warfarin) and COPD and lived at home alone prior to becoming unwell.

On 29th May 2015, at the recommendation of the MDT at UHW, SP underwent laparoscopy which confirmed absence of peritoneal disease. On this basis SP was deemed to be a candidate for liver resection, a potentially curative operation. Liver resection is a complex and high risk procedure with an associated mortality of 8-12%. However, chemotherapy is not effective for cholangiocarcinoma so without surgery life expectancy is a matter of months. SP was listed for surgery in June 2015 at UHW under the care of a liver surgeon, Mr K.

While an inpatient at UHW SP continued to receive thromboprophylaxis in accordance with hospital policy. On 1st June 2015 SP’s condition deteriorated. SP complained of severe pain in her back and lower abdomen with radiation down her left leg. A CT abdomen on 1st June revealed no haemorrhage or haematoma. The surgical team considered metastatic spread as a diagnosis and requested an orthopaedic review. An MRI was requested but not performed. Instead, an assessment was made using the previous CT imaging and an orthopaedic cause for the pain was ruled out. By 2nd June 2016 a mass was noted in the left iliac fossa by medical and nursing staff and SP continued to be in severe unremitting pain.

On the evening of the 3rd June 2015 SP was reviewed by Mr K. Blood results were available at 5pm but when SP was reviewed by the Consultant at 7pm these results were not seen nor acted upon and the decision to give treatment dose enoxaparin (to prevent blood clots) was made by the consultant. (On 3/6 Haemoglobin had dropped to 92 having been 132 on admission) Haemorrhage was considered overnight by the registrar on call. A CT scan was requested at this stage but was refused by the radiologist on the basis that the clinical picture had not changed and this investigation was not indicated. This decision was not challenged by Mr K.

A CT scan was finally performed on 4th June 2015 following further clinical deterioration characterised by oliguria, tachycardia and hypotension. A delay of over 6 hours in obtaining the result of the CT scan followed owing to technical difficulties encountered between UHW and the remote radiology provider in Australia. Once the scan was reported, some 6 hours later, a large haematoma consistent with retroperitoneal haemorrhage was identified. Attempts were made to reverse the anticoagulation and red cell infusion was given. At angiography no definitive bleeding point was identified and it was on this basis that SP was not deemed to be a candidate for embolisation.

SP continued to deteriorate and having been as an “advanced stage down the road to surgery” was not considered to be a candidate for HDU/ITU on the basis that she was not now a candidate for potentially curative resection owing to her “performance status”; she was considered now to be “too high a risk”. SP remained on the ward where resuscitation measures were unsuccessful. SP died on the afternoon of 4th June 2016.

A post-mortem examination was performed and the medical cause of death was stated as:

---

**continued on page 20**
Pro bono inquest cases: Inquest touching the death of SP

continued from page 19

1A Retroperitoneal haemorrhage
1B Anticoagulant therapy

Conclusion
SP died of complications from necessary medical treatment.

Involvement of AvMA
The inquest was listed for 1 day in September 2016 before senior coroner for Cardiff. Mr Thomas Banks of 12 Kings Bench Walk was instructed by AvMA after SP’s family approached AvMA’s pro-bono inquest team.

Issues in this case
1. Cause of the haemorrhage: IVC filter perforation of the IVC v spontaneous bleed secondary to thromboprophylaxis
2. Delay in diagnosis and management of a major retroperitoneal bleed
(c) Administration of therapeutic dose of heparin when there were clinical signs of haemorrhage

1. Cause of bleed
The pathologist, Dr M, gave evidence that there was a full thickness defect, approximately 4mm in size, in association with a limb of the IVC filter with adherent clot. The defect and the clot were in continuity in addition to approximately 2 litres of blood in the abdominal cavity. A review of the literature provided by Dr M revealed that while perforation/erosion of the IVC is not uncommon, there have been no reports of a major haemorrhage secondary to erosion as described in this case. This being the case, Dr M opined that this case may represent a unique finding worthy of a scientific case report. In Dr M’s opinion the bleed was more likely than not to have arisen from this site.

Dr W, an independent expert in radiology instructed by the Coroner also gave evidence on the cause of the bleed having reviewed the available imaging. Dr W had considered that the bleed was spontaneous in nature although having listened to the post-mortem findings Dr W did concede that it may have been possibly the result of erosion of the strut. Dr W opined that the imaging was more likely than not consistent with spontaneous haemorrhage.

The Coroner accepted evidence that the bleed was more likely to have been venous in nature than arterial given that there was no identifiable artery at post-mortem or on imaging and the “slow to medium” estimate of the rate of haemorrhage given. He concluded that on the balance of probabilities the bleed had been spontaneous secondary to anticoagulation therapy. It is noteworthy that current practice is to retrieve these IVC filters rather than leave them in situ as in this case.

2. Delay in the diagnosis and management of the haemorrhage
The management of retroperitoneal haemorrhage was explored by the Coroner with Mr K. The evidence was that such haemorrhages were rarely operated on, save for exceptional circumstances where they have arisen from trauma. The mainstay of treatment is conservative with the withholding of anticoagulant therapy and reversal of its effects coupled with resuscitation of the patient.

During questioning Mr K conceded that SP was at high risk of a bleed owing to her anticoagulant medication, that there were signs of haemorrhage characterised by oliguria, hypotension and tachycardia and low haemoglobin evident on 3rd June 2015 and that ultimately there had been delays in the diagnosis and management of the haemorrhage. However, in Mr K’s opinion these delays had not altered the outcome.

With specific regard to delays in obtaining the CT scan results, the coroner stated that there was “no blame for that” but did add that it inevitably led to further delays in SP receiving treatment. The delays evident in this case certainly raise concerns about the use of remote radiological reporting in such circumstances and the systems in place locally for emergency situations. In this case, there appeared to be a lack of familiarity among members of the surgical team with local policies whereby on-call radiologists were available locally albeit not resident in the hospital overnight. This was not fully explored at the inquest but had the local systems been known to the staff on duty, it is arguable that local personnel could have reported the scan earlier which would have prompted earlier reversal of the anticoagulants and resuscitation efforts and may have led to a better outcome.

Once the haemorrhage was known however, the Coroner was satisfied that the appropriate care was taken. Having looked at the legal tests and errors the Coroner was continued on page 21
satisfied that these did not make any difference to the outcome and did not find that these errors amounted to neglect in a Jamieson or Khan sense. However, while the coroner declined to add a rider of neglect to his narrative conclusion he did acknowledge in his closing remarks that:

There was no doubt that errors were made. It was an error not to look at the blood results at 1920 by Mr K. Had he done so he would have been persuaded that this was a haemorrhage. It was an error that anti-coagulation medication was given at 1830. It may also have been an error that reversal therapy was not given sooner.

Such criticism suggests that while the threshold for neglect was not thought to have been made out in this case, it is arguable that the mismanagement of the retroperitoneal haemorrhage may have contributed more than minimally, negligibly or trivially to the death of SP and Counsel advised the family to seek specialist legal opinion on the merits of a civil claim on this basis.