

VERONICA HAMILTON-DEELEY, LL.B.  
Her Majesty's Senior Coroner  
for the City of Brighton & Hove



THE CORONER'S OFFICE  
WOODVALE, LEWES ROAD  
BRIGHTON  
BN2 3QB

Assistant Coroners  
CATHARINE PALMER LL.B (HONS)  
MICHAEL KEEN  
KAREN HENDERSON, BSC, BM, MRCPI, FRCA  
GILVA D.J. TISSHAW, BA (LAW) HONS

Telephone: Brighton (01273) 292046  
Fax: Brighton (01273) 292047

## CORONERS SOCIETY OF ENGLAND AND WALES

### ANNEX A

#### REGULATION 28: REPORT TO PREVENT FUTURE DEATHS (1)

*NOTE: This form is to be used **after** an inquest.*

	<p><b>REGULATION 28 REPORT TO PREVENT FUTURE DEATHS</b></p> <p><b>THIS REPORT IS BEING SENT TO:</b></p> <ol style="list-style-type: none"><li>1. <b>Mr. Mathew Kershaw</b>, Chief Executive, Brighton and Sussex University Hospitals NHS Trust – Royal Sussex County Hospital, Brighton.</li><li>2. <b>Discharge Coordinator</b>, The Princes Royal Hospital, Haywards Heath</li><li>3. [REDACTED] Medico-Legal Services Manager, Royal Sussex County Hospital, Brighton</li><li>4. [REDACTED] – (Consultant in charge of Mr. Watts) Consultant Physician in the Department of Elderly Health – The Royal Sussex County hospital, Brighton.</li></ol>
<b>1</b>	<p><b>CORONER</b></p> <p>I am Veronica HAMILTON-DEELEY, Senior Coroner, for the City of Brighton and Hove</p>
<b>2</b>	<p><b>CORONER'S LEGAL POWERS</b></p> <p>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.</p>
<b>3</b>	<p><b>INVESTIGATION and INQUEST</b></p> <p>On <b>9<sup>th</sup> December 2013</b> I commenced an investigation into the death of <b>Graham Harold WATTS</b>. The investigation concluded at the end of the inquest on <b>2<sup>ND</sup> April 2014</b>. The conclusion of the inquest was</p>
<b>4</b>	<p><b>CIRCUMSTANCES OF THE DEATH</b></p> <p>See Record of Inquest</p>



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5	<p><b>CORONER'S CONCERNS</b></p> <p>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.</p> <p>The <b>MATTERS OF CONCERN</b> are as follows. –</p> <ol style="list-style-type: none"><li>(1) That the Discharge procedure followed in respect of Mr. Watts' discharge from the Princess Royal Hospital in Haywards Heath, West Sussex on the 4<sup>th</sup> December 2014 was deeply flawed. There was no ongoing process of discharge.</li><li>(2) The discharge paperwork was effectively blank.</li><li>(3) There was no communication as to the discharge, either with regard to the anticipated date of discharge or with the Nursing Home who were expected to receive him back or with Graham Watts' son. He was medically unfit for discharge arriving back at his Nursing Home hypothermic, hypotensive, oedematous and sleepy.</li><li>(4) It is acknowledged and accepted that a change of environment increases the risks of fall.</li><li>(5) Evidence was heard to the effect that if Mr. Watts had not fractured his hip when he fell, he would not have died when he did.</li></ol>
6	<p><b>ACTION SHOULD BE TAKEN</b></p> <p>In my opinion action should be taken to prevent future deaths and I believe you AND your organisation have the power to take such action.</p>
7	<p><b>YOUR RESPONSE</b></p> <p>You are under a duty to respond to this report within 56 days of the date of this report, namely by <b>22<sup>nd</sup> May 2014</b>. I, the coroner may extend the period.</p> <p>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.</p>
8	<p><b>COPIES and PUBLICATION</b></p> <p>I have sent a copy of my report to the Chief Coroner and to the following Interested Persons</p> <ol style="list-style-type: none"><li>1. Secretary of State for Health, Department of Health</li><li>2. Sir David Nicholson/Simon Stevens – Chief Executive NHS England</li><li>3. National Patient Safety Agency</li></ol> <p>I have also sent it to:-</p> <ol style="list-style-type: none"><li>1. [REDACTED] – Son of the late Mr. Graham Harold Watts)</li><li>2. [REDACTED] – SECOS</li><li>3. [REDACTED] – Safeguarding Adults Lead, Sussex Community NHS Trust, Horsham</li><li>4. [REDACTED] – Manager, Fir Grove Nursing Home, Burgess Hill, West Sussex</li><li>5. [REDACTED] Team Manager, Adult Safeguarding Services, County Hall North, Horsham</li></ol>

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	<p>6. <b>Clinical Commissioning Group</b> – Brighton and Hove CCG, Brighton 7. Nurse in charge of Ardingly Ward – Princess Royal Hospital, Haywards Heath, West Sussex</p> <p>Who may find it useful or of interest. I am also under a duty to send the Chief Coroner a copy of your response.</p> <p>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.</p>
9	<p><b>Date:</b> 3<sup>rd</sup> April 2014      <b>SIGNED BY:</b> <i>V Hamilton-Deeley</i></p> <p style="text-align: center;"><b>Senior Coroner Brighton and Hove</b></p>