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

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

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

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.

	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS
	THIS REPORT IS BEING SENT TO:
	 Matthew Kershaw, Chief Executive, Brighton & Sussex University Hospitals NHS Trust, Royal Sussex County Hospital, Eastern Road, Brighton Chief Nurse, Brighton & Sussex University Hospitals NHS Trust, Royal Sussex County Hospital, Eastern Road, Brighton
1	CORONER
	I am Veronica HAMILTON-DEELEY, Senior Coroner, for the City of Brighton and Hove
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.
3	INVESTIGATION and INQUEST
	On 7 th November 2014 I commenced an investigation into the death of Mrs. Evelyn KENNEDY. The investigation concluded at the end of the inquest on 21 st April 2015. The conclusion of the Inquest was: Mrs. KENNEDY died of hospital acquired pneumonia. Her death was probably accelerated by a short time because of the effects of her 5 day admission to the Acute Medical Unit at The Royal Sussex County Hospital, Brighton. This admission was characterised by suboptimal care in almost every respect. During Mrs. KENNEDY's stay there were breaches of 5 of the hospital's own policies which directly affected her. For Mrs. KENNEDY the Acute Medical Unit was chaotic and not fit for purpose.
4	CIRCUMSTANCES OF THE DEATH
	Mrs. KENNEDY was a frail 89 year old lady who was living at a Rehabilitation Unit where she had a number of multifactorial minor injury falls. She came to The Royal Sussex County Hospital by ambulance on 14.10.2014 and was admitted to the Acute Medical Unit on 15.10.2014. She remained there until the 20 th when a bed was found for her on Bristol Ward. On arrival at Bristol Ward staff raised a Vulnerable Adult Alert. Mrs. KENNEDY remained on the ward until her death on 29 th October 2014.

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Ε	Τ
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
	 Once again my concerns involve the Acute Medical Unit (AMU). Mrs. KENNEDY was transferred from AMU in a chair, not a trolley. Handover was incomplete and unhelpful. She arrived unkempt. She had porridge leaking from her mouth; it took 20 mouth sponges to give her adequate mouth care. She felt cold and said she was cold.
	(7) She had been incontinent of faeces and had not been cleaned for some time. (8) She had no name wrist band.
	(9) In spite of known allergies she had no allergy wrist band.
	(10) In spite of falling regularly she had no falls risk wrist band.
	(11) She still had an IV cannula in place; this should have been removed after 72 hours.
	(12) Her daily catheter care bundle had not been completed for 3 days. (13) She had no fluid charts for 16 th , 17 th , 18 th , 19 th or 20 th . (14) Care plans were not completed for 17 th , 18 th , or 19 th .
	(14) Care plans were not completed for 17 th , 18 th , or 19 th .
	(15) Repositioning charts were incomplete or poor for 16 th , 17 th , 18 th and 19 th
	(16) The handling assessment was not completed for 16 th , 18 th , 19 th or 20 th .
	(17) No food chart was completed for her entire time in AMU. (18) She had pressure damage to her hips and bottom.
	(19) No daily oral assessment was completed for her entire time on AMU.
	(20) She was not weighed.
	(21) The malnutrition tool was not completed.
	(22) Her bowel movements were not recorded. (24) NEWS scores of 4 to 9 had not been escalated to doctors nor filled in on her drug chart.
	PLUS
	(25) No personal care over the weekend of 18 th and 19 th .
	(26) No senior review over that weekend.
	(27) Not written up for her Sertraline, therefore not given (28) Not written up for any food supplements until 21 st October.
	(29) She should have been specialled, but wasn't.
	Once again AMU has been found to be chaotic and not fit for purpose.
6	ACTION MUST BE TAKEN
	In my opinion action must be talken to prove that the first transfer to the state of the state o
	In my opinion action must be taken to prevent future deaths and I believe you AND your organisation have the power to take such action.

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7	YOUR RESPONSE
	You are under a duty to respond to this report within 56 days of the date of this report, namely by 27 th July 2015. 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
	1. Clinical Commissioning Group 2. Clinical Commissioning Group
	 Secretary of State for Health, Department of Health Simon Stevens – Chief Executive NHS England
	5. National Patient Safety Agency6. Department of Health
	I have also sent it to:-
	1. 2. 3. 4. Counsel for Brighton and Hove City Council,
	5. Craven Vale Resource Centre 6. C24, Craven Vale Resource Centre,
	7. Adult Social Care, Brighton and Hove City Council
	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	Date: 7 th May 2015 SIGNED BY:
	Veronica HAMILTON-DEELEY
	Senior Coroner Brighton and Hove