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

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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:** 1. **Dr. Gillian Fairfield, Chief Executive, Brighton and Sussex University Hospitals NHS Trust, Royal Sussex County Hospital, Eastern Road, Brighton** 2. [redacted] **Medico-Legal Manager, Brighton and Sussex University Hospital 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 14th September 2015 I commenced an investigation into the death of Mrs. Christine Street. The investigation concluded at the end of the inquest on 29th April 2016.The conclusion of the inquest was **NARRATIVE CONCLUSION.** **Following admission to hospital on 22nd August 2015, Mrs. Christine Valerie STREET was diagnosed with an aggressive brain tumour. Her symptoms were disorientation, confusion and a generalised left-sided weakness affecting capacity to mobilise and leaving her prone to falling.** **This left her in need of continuous one-to-one care and assistance when mobilising.** **Due to her lack of mental capacity and attempts to leave the hospital, Mrs. STREET was subject to a Deprivation of Liberty Safeguarding Order.**

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	Following a loud noise at approximately 5:30am on 11th September 2015, she was found lying unattended on the toilet floor following an unwitnessed fall. **The resulting head injury was minor but had a traumatic impact and accelerated the pace of her deterioration and timing of her death**
4	**CIRCUMSTANCES OF THE DEATH** See Record of Inquest
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. – (1) Documentation with regard to the admission document (which was not completed) and the doctors pro forma to document the fall on the 11th September 2015 (was not completed). The lack of these documents did not affect the outcome, but it is bad practice that they were not completed and placed with Mrs. Street's notes. (2) Mrs. Street was being specialled. She was on arm's length observations and had been since just after her biopsy on the 28th August 2015. These observations had apparently been carried out successfully over the following days until early on the morning of the 11th September when an experienced HCA was specialling her. It was clear that he knew exactly how he should be specialling her, it was clear that the handover to him on the 10th September had been effective. It comprised a general handover, a bedside handover and a handover sheet. The handover sheet was flawed since it suggested that Mrs. Street had, had a fall already on the 9th September. There was no evidence to suggest that this was in fact the case. For some reason on the occasion when he escorted Mrs. Street to the toilet, a few steps from her bed in bay 9 on Level 8a West and indeed a few steps from the nurses station because bay 9 is a high dependency bay, he left her in the toilet, closed the door and did not wait outside. A few moments later she had an unwitnessed fall, the nurse at the nursing station heard the noise and rushed in to find her on the floor with a head injury which was immediately obvious. He looked after her and she was taken by wheelchair back to her bed once it had been established that she did not appear to have any injury other than the head injury. Thereafter, on the 11th she was appropriately managed. The Trust policy on observations for patients with mental health illness (this lady was deemed not to have mental capacity due to the extent of the symptoms produced by the brain tumour and was the subject of a Deprivation of Liberty Safeguarding Order put in place urgently on the 31st August 2015) was not adhered to by the HCA. The Trust policy on observations includes good paperwork for specialling including a specialling document which will stay with the care plan and daily documentation as to the specialling, plus an observation sheet. Apart from one or two observation sheets which appear to have been done on the 31st August, there was absolutely no documentation at all. This was in direct contravention of the Trust's own policy and indeed of the NICE guidance on observations, i.e., the national policy.

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	There was another problem in connection with specialling and that is that the HCA involved was a bank employee and therefore the Trust has apparently no power over his training but must rely on the assurance of the agency that their staff have been appropriately trained for the tasks they are to perform. This gives no guarantee of course that they are trained to the standards set out in the Trust's own policies and although the policies are handed to these members of staff or their existence made known to them, so that they can access them through the intranet, it seems highly unlikely that they would necessarily have had time or inclination to access every single one of the many protocols which exist in any acute hospital Trust. The problem was overcome here and was not a direct matter for the Jury to explore in this Article 2 Inquest because from the evidence, it was clear that the HCA concerned was experienced, had worked in the neurosurgical unit before and had done specialling on many occasions before and so would have known exactly what was expected of him. Nonetheless, important documentation such as this must be completed appropriately. (3) From the 12th September 2015 the recording of doctor's visits, of nurses observations and the processes around the recognition of the dying patient were utterly flawed, unprofessional and unacceptable. I do not propose to rehearse all the things that went wrong since I am quite sure that there should now be a full investigation into what happened by the hospital. This is not the first Regulation 2 report that I have had to write recently (in the last few months) following Inquests and concerning the hospital's failure to recognise the dying patient and act appropriately and in accordance with their own and with national guidance. This is a matter which exercises everyone these days particularly following the discussion which arose following the Liverpool Care Pathway AND IT MUST be addressed by this hospital Trust. This abject failure did not, the Jury accepted from the evidence, affect the care that Mrs. Street was given following her fall and head injury. The lack of recognition and the lack of procedures did not affect her and therefore did not either cause or more than minimally contribute to her death, which is why this Regulation 28 Report is so important. These failings did however have a huge impact on her large and loving family who were denied all the support that they should have been given as set out in the End of Life Care Protocols for this Hospital Trust.
6	**ACTION SHOULD BE TAKEN** 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.
7	**YOUR RESPONSE** You are under a duty to respond to this report within 56 days of the date of this report, namely by 2nd August 2016. 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.

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8	**COPIES and PUBLICATION** I have sent a copy of my report to the Chief Coroner and to the following Interested Persons 1. Medical Director, Neurological Unit, Royal Sussex County Hospital, Brighton 2. Secretary of State for Health, Department of Health 3. Simon Stevens – Chief Executive NHS England 4. National Patient Safety Agency 5. Clinical Commissioning Group 6. Peter Wilkinson – Director of Public Health 7. [redacted] – Chair of BSUH NHS Trust 8. [redacted] – Director for Clinical Quality and Primary Care I have also sent it to:- 1. [redacted] 2. [redacted] 3. [redacted] End of Life Care Facilitator 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:** **10th May 2016** **SIGNED BY:** Veronica Hamilton-Deeley **Veronica HAMILTON-DEELEY** **Senior Coroner Brighton and Hove**