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.*

	THIS REPORT IS BEING SENT TO: 1. **Brighton and Sussex University Hospitals NHS Trust, [redacted]** 2. **Dr Gillian Fairfield, Chief Executive, Brighton and Sussex University Hospitals NHS Trust**
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 25th July, 2016 I commenced an investigation into the death of Mr Raymond Frank POLLARD. The investigation concluded at the end of the inquest on 19th January, 2017. The conclusion of the inquest was a **Narrative Conclusion.**
4	**CIRCUMSTANCES OF THE DEATH** At the Inquest I heard evidence concerning the failed discharge which took place on the 28th Jun 2016. Mr Pollard came into hospital as an emergency on the 10th June with a community acquired pneumonia. He spent several days in the intensive care unit before being transferred to the respiratory ward. The main problems related to his respiratory difficulties and his renal problem which were resulting in metabolic acidosis and high potassium levels. These conditions needed treating and monitoring. Arterial blood gases revealed that Mr Pollard was improving but from the 25th June and through the 26th and into the 27th June he was quite unwell with potassium levels at 5.6, 5.7, 6 (in the early hours of 27/6) and 5.8 on the 27th at 10 a.m.

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PH levels were also giving rise to some concern.

At a ward round on the 27th June (09.50 hrs) a decision was made that he was fit for discharge 'today'.

There were no further arterial blood gases done, therefore no further checks on his potassium levels and his PH.
Mr Pollard was not seen again by a Doctor prior to his discharge.

NEWS scores were kept during the 25th, 26th, 27th and 28th June. At Inquest I was told that his average or baseline was probably between 3 and 4 or possibly 3 and 5.

On the 25th his four NEWS scores were 1, 4, 3 and 2
On the 26th his four NEWS scores were 4, 7, 5 and 7
On the 27th his four NEWS scores were 6, 8, 10, 6, 1 and 6
On the 28th (06:05 hrs) the last time they were calculated his NEWS was 6
Therefore on average above his baseline.

Mr Pollard was moved from Catherine James Ward to Overton Ward on the 27th. He went to the discharge lounge at 10 to 10.20 hrs there was no ward round involving him and no reassessment of him before he was discharged which according to the Discharge Summary happened at 11.30 hrs. He arrived at his rehab nursing home at midday having walked from the ambulance to his room (he had not taken any substantial amount of exercise since he had been admitted on the 10th June).

It became clear that he was very shut down and unresponsive and obviously unwell. Some four hours after he had arrived, after persuasion by his wife, an ambulance was called and he was found to be extremely unwell with a NEWS of 8.

He was taken urgently to the Royal Sussex County Hospital, Brighton where a chest x-ray showed progression of chest consolidation and where at 1800 hrs that day his PH was low at 7.2 and his potassium level was high at 8.

Mr Pollard effectively needed resuscitation and decisions about his treatment.

Within a couple of days his status had changed from someone who was fit to be discharged to a rehabilitation unit to a seriously unwell patient who was not fit for haemo filtration, whose ceiling of care would be ward based and by the 4th July end of life medications were put in place and he was placed on the end of life pathway.

The evidence to me at the Inquest was that the Hospital accepted that this was unsatisfactory. It will review its discharge practices and will also give consideration

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	to ensuring a medical review prior to discharge in a complex patient with fluctuating 'numbers' where the patient has not been discharged within 18 to 24 hours of the discharge decision.
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) A poorly informed decision to discharge made for a patient with no real Improvement in his condition. (2) The patient was not seen again by a doctor or reviewed as to suitability for discharge. (3) As a result the discharge failed and this failure seriously compromised Mr Pollard.
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 14th April 2017 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. [redacted] 2. 3. Secretary of State for Health, Department of Health 4. Simon Stevens – Chief Executive NHS England I am also under a duty to send the Chief Coroner a copy of your response.

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	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: 25th January 2017** **SIGNED BY:** V Hamilton Deeley **Senior Coroner Brighton and Hove**