VERONICA HAMILTON-DEELEY DL, 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. **Sussex Partnership Trust -** [redacted] 2. **Sussex Partnership Trust –** [redacted] 3. [redacted] **Matron, Brunswick Ward, Lindridge, Laburnum Avenue Hove**
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 5th June 2016 I commenced an investigation into the death of **Derek LEE**. The investigation concluded at the end of the inquest on the 6th February 2017. The conclusion of the inquest was **NATURAL CAUSES.**
4	**CIRCUMSTANCES OF THE DEATH** See Record of Inquest
5	**<u>CORONER'S CONCERNS</u>** 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.

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The **MATTERS OF CONCERN** are as follows and were set out very clearly in my summing up:-

(1) Mr Lee's medication regimen which was to be the core of the admission was barely addressed and no reasons for any changes in medication appear in his notes.

(2) Re: Admission Documentation – Mental capacity was not properly assessed and when Mr Lee was discharged from the ward after three weeks on the 17th May the paperwork in that respect was still incomplete.

(3) His Falls Risk Assessment was flawed in that it failed to take into account information from his wife and son as to how he was mobilising at home. Mobilisation in Mr Lee's case should have been at the core of the Care Plan because he was suffering from Parkinson's Disease, where if possible, it is important to maintain mobility. Brunswick Ward should know that.

(4) No Waterlow score was done until the 4th May. Too late. No appropriate pressure relieving equipment was ordered until the 12th May. There was no evidence before me that the equipment was ever received or used for Mr Lee. When Mr Lee was admitted to the Acute Hospital he had a Grade 2 pressure sore on his Sacrum.

(5) The thromboprophylaxis assessement which should have been carried out on either the 27th or 28th April was not done until the 6th May.

(6) No bowel chart was kept until the 12th May. Why not? Even non nursing, non-medical professionals know that one of the several dangers of Parkinson's Disease is constipation.

(7) Medical instructions and recommendations were not handed over. One example relates to instructions to clean Mr Lee's infected eyes with saline every two hours to keep them open. This was not done and when he arrived at the Acute Hospital his eyes were crusted shut.

(8) The MUST score was properly calculated on admission but not reviewed when it was clear he was not eating.
There was no evidence of any reaction to Mr Lee's substantial weight loss.
There was no referral to dieticians. They just happened to attend a multi-disciplinary meeting on the 9th May (he was admitted on the 27th April and by the 9th May had lost 10 and ¾ pounds – 4.80 kilos.
Re-weighing was requested by the dieticians. It did not take place.

(9) There was no evidence of dates when Mr Lee was referred to the Occupational Therapist, the Physiotherapist, the dieticians or the Parkinson's Specialist Nurse. At the Inquest I heard evidence that these referrals should have taken place as soon as possible after admission and certainly within the first three or four days. It is clear from the

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evidence that very little happened so far as Mr Lee was concerned until the 9th May. Too late.

(10) There was apparently no appreciation of the deterioration in Mr Lee's mobility. He was at high risk of falls and yet the mobilisation of a Parkinson's patient is imperative and also since he was being specialled during his entire admission there is absolutely no excuse for not trying to assist him with mobilising.

(11) It was not until the 12th May – two weeks after Mr Lee's admission to Bruswick Ward – that he was seen by the Parkinson's Nurse Specialist. When the Specialist Nurse saw Mr Lee he made three important recommendations and asked for feedback within seven days – the referral to the Speech and Language Therapy Team was done the next day.
The enema did not take place for two days. Too long and possibly dangerous.
The change in medication was never even discussed.

(12) As time went on there was no regular review of his original Assessments. This should have been done apparently by his Primary Nurse who carried out none of these functions and therefore her appointment for Mr Lee was irrelevant.
There should be a review of the role of Primary Nurse.

(13) There was no coherent and carefully considered and reviewed Care Plan.

(14) A Care Co-ordinator was not appointed, even though at the Inquest, it was confirmed that Mr Lee was being looked after on the Care Programme Approach (CPA).
The appointment of a Care Co-ordinator is at the heart of this framework and it was clear that such an appointment could have been helpful if not crucial in Mr Lee's case.

Brunswick is supposed to be a specialist unit for patients with Mr Lee's problems and yet it is clear that he was failed most miserably. It is equally clear that these specific failings, even in combination and on the balance of probabilities did not change the outcome (ie. Mr Lee's death) on the 5th June 2016, however they were all matters that need addressing in order to raise the standard to an appropriate level for the proper care of these vulnerable patients.

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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 **3rd 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. [redacted] (Junior) 3. [redacted] 4. Secretary of State for Health, Department of Health 5. Simon Stevens – Chief Executive NHS England 6. Care Quality Commission 7. Brighton and Hove Clinical Commissioning Group 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: 14th February 2017** **SIGNED BY:** V Hamilton-Deeley **HM Senior Coroner**