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..
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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. Dr. Gillian Fairfield, Chief Executive, Brighton and Sussex University Hospital NHS , 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 7th June, 2016 I commenced an investigation into the death of **Leslie Isaac LERNER**. The investigation concluded at the end of the inquest on 18th October, 2016.The conclusion of the inquest was a **NARRATIVE CONCLUSION**.
4	**CIRCUMSTANCES OF THE DEATH** See Record of Inquest

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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: **13th May 2016** (1) Junior Doctor applied wrong sling with wrong knot for Mr Lerner after she had learned that he had had a fractured shoulder which was to be treated conservatively. **I heard that a Nurse should have applied the sling because the chances are that he or she would have known which sling to use and how to apply it.** (2) Although the Junior Doctor discussed Mr Lerner with her Senior, the Senior did not actually see him nor specifically state which type of sling (should have been a collar and cuff) should be applied. **I was told that the Senior should always see the Patient.** **14th May 2016** (1) Mr Lerner was kept in the Royal Sussex County Hospital overnight and towards the middle of the day he was discharged without a Senior Review. **I was told that before he was discharged he should have been seen by a Senior Doctor and it may well have been that the inappropriately applied sling would have been recognised.** He was sent home with no analgesia. **He should have been given analgesia**. It became clear from the evidence that the pain that he suffered was very much part of his overall deterioration and an exacerbating factor with his dementia. **The Hospital's own Discharge Protocol was not followed, it should have been.**

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15th May 2016

(1) Mr Lerner was back at the RSCH, by ambulance at 1006 hrs in considerable pain and discomfort. He was seen by the Consultant in Elderly Medicine at 1645 and was given analgesia at 1700 hrs – ie almost 7 hours after he arrived at the hospital.

This is completely unacceptable, this man was in pain from the fracture and he should have been given pain relief.
At that stage he should also have been reviewed by the Orthopaedic Team, no such review was organised.

16th May 2016

(1) Having been admitted to a renal ward, because of lack of beds elsewhere, a member of the medical staff had a telephone discussion with a member of the Orthopaedic Team and a collar and cuff sling was recommended. This information was not passed onto the Nursing Staff, not properly documented nor was the Patient actually seen by a member of Orthopaedic Team. **He should have been seen and a note should have been made.**

(2) He then was moved to another ward, again not an Orthopaedic Ward, where any chance of correct hand over seems to have been lost because he was transferred to Baily Ward in the middle of the night. **No proper handover.**
There was no referral to physiotherapists and yet the Trusts own paperwork says that exercises should be given by a Physiotherapist and commenced by the patient after seventy two hours of the fracture occurring. **No speedy referral to physiotherapists.**
Within his notes was an utterly inadequate document explaining what the Patient needs to do with a fractured shoulder, however, as the Ward Manager pointed out it does not say what type of sling should be applied for this particular Patient and so she apparently had no idea anything was amiss. **This document was not fit for purpose either for the patient or the ward.**

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17th May – 22nd May 2016

There is no evidence of any continuity of care.
There is good evidence of "hands off" care and nursing.
In spite of anxieties expressed by the Manager of Mr Lerner's Rest Home, who came to assess him on the 19th May having been told he was medically fit for discharge (which he was not) and by his nephew Mr Marsh that he seemed 'chesty' and so far as the Manager was concerned that she was worried about the sling which did not seem to be supporting his elbow and did not seem to be 'right', there was no appreciation of the possibility that the sling was causing half the problems at least that Mr Lerner was suffering.

No efforts were made to see whether he was 'chesty'; a Doctor was not called, another chest x-ray was not ordered and it was not until the next day he was found to have a bilateral pneumonia which needed intravenous antibiotics.
In addition he was being nursed at the wrong angle and it seems clear that he couldn't have been given any personal care such as washing, because if he had been, nursing staff or healthcare assistants would have seen the tightness of the sling and the damage that it was causing.

22nd May 2016

(1) This was the day (nine days after its application) that hospital staff realised that the sling was incorrectly tied, and of the wrong type, and had caused a long deep Grade 2 pressure sore and necrotic ulcerated area where it had been pressing into the back of Mr Lerner's neck. Every time he was moved and repositioned this wound will have chaffed and given him extra pain.

With regard to his medications: these were either given at a level at which he was completely unable to communicate and co-operate and unable to realise that his family were visiting him, or left him in such pain that he was quite unable to manage it, as a result of this, his dementia and confusion worsened.

A wound care nurse referral was made on the 22nd May and he was seen on the 23rd May at 2 p.m.

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	It was not possible now to apply any sling and it wasn't until a few days after that, that any careful thought was given to supporting his arm and shoulder in such a way as to minimise the pain. From the notes, once the sling had been removed Mr Lerner himself appeared brighter and less confused, however this improvement was short lived. He deteriorated but end of life care was not initiated until the 31st May and he died at 0835 hrs on the morning of the 3rd June. In Court the Elderly Care Consultant accepted that there had been **delay in recognising Mr Lerner as a dying patient.** This case showed evidence of lack of communication, lack of care, lack of continuity of care, too much use of 'virtual' clinics and a general "hands off" attitude towards this patient.
	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 **18th January, 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] - Nephew 2. [redacted] Manager, Brittany Lodge Rest Home, 32 Brittany Road, Hove 3. Secretary of State for Health, Department of Health 4. Simon Stevens – Chief Executive NHS England 5. Care Quality Commission

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<table>
<tr><td></td><td>I have also sent it to:-

1. [redacted], Medico Legal Department, Royal Sussex County Hospital,
2. [redacted], Ward Manager, Baily Ward, Royal Sussex County Hospital, Eastern Road, Brighton
3 [redacted] Consultant in Elderly Medicine, Royal Sussex County Hospital, Eastern Road, Brighton.
4. [redacted], Consultant in Emergency Medicine, Royal Sussex County Hospital, Eastern Road, Brighton

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.</td></tr>
<tr><td>9</td><td>Date: 28th October, 2016 SIGNED BY:
V. Hamilton-Deeley
Veronica HAMILTON-DEELEY
Senior Coroner Brighton and Hove</td></tr>
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