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

THE CORONER'S OFFICE
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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. **Mr. Matthew Kershaw, Chief Executive Brighton & Sussex University Hospital NHS Trust** 2. [redacted] **Head Consultant, A&E Department, Royal Sussex County Hospital, Eastern Road, Brighton** 3. **Matron, Emergency Department, 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 **18th June, 2014** I commenced an investigation into the death of **Maureen Annette ELLETT**. The investigation concluded at the end of the inquest on **21st October 2014**. The conclusion of the inquest was **A NARRATIVE CONCLUSION AS PER THE ATTACHED SHEET**
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) Initial A & E paperwork was flawed as no blood pressure or Glasgow Coma scales were recorded on the front sheet.

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Acopia was recorded as the main diagnosis.
None of the early A & E paperwork was completed.
The N.E.W.S. score from the first set of observations taken on arrival at A & E was not completed.
No Admission bloods were taken and in this respect there is no protocol or guidance concerning:

a) that bloods should be taken when patients are admitted to A & E by Ambulance or
b) who should take these bloods.

(2) Discussion by the Junior Doctor with the Senior Doctor as to the plan for Mrs. Ellett was brief to the point of transient.
No proper detailed plan was formulated.
Clues to the patient's condition were missed, probably because the discussion was so brief and the paperwork required for transfer to the short-stay ward, also known as the Clinical Decisions Unit, was signed by the A&E Consultant but neither dated nor timed by him.
The plan was incomplete and the counter-signatory of the Senior Nurse with date and time was completely missing. Therefore the transfer should not have taken place.

(3) No notice appears to have been taken that the junior Doctor, discussing with the Senior was an Agency Doctor who had only worked in this busy department on two previous shifts in the last three weeks. Her last experience in an Emergency Department had been eleven months earlier when she did her rotation training. It is suggested that if the Junior Doctor is not a regular member of staff this should be noted when the Senior Review takes place to ensure that no mistakes, due to inexperience or lack of knowledge of the Hospital's own systems is impinging on the Junior Doctors work.

(4) The second Triage Nurse in A & E did the assessment on Mrs. Ellett at the end of a 12½ hour shift which was due to end at 20:00 hours on the 16th June, 2014. She saw Mrs. Ellett at approximately 19:20 hours and out of the two pages of emergency department Nursing Documentation which require over 80-pieces of information recorded, she recorded merely 12 pieces of information. The Falls Risk Assessment was completely blank and yet Mrs. Ellett was at high risk of falls and should have been provided with a green wrist band to alert all staff to this. It is thought that this shift is too long and at the end of it, staff who have had no proper breaks will be exhausted.
It is considered that all staff should be trained on the importance of completing hospital documentation.

(5) There are no ECG machines in the Clinical Decisions Unit; either they should be provided or staff on the Clinical Decisions Unit should not be expected to perform ECG's there.

(6) When the ECG is shown to one of the Doctors there should be a proper documented note of the identity of the Doctor, the time and date when he or she reviews the ECG, the Doctor's instructions on what should happen next with a time period within which this is to occur and this note should be signed and timed by the Doctor who should also print his or her name.

(7) If, as in this case, the first ECG is unclear; rather than simply requesting that it should be repeated, the Doctor who reviews it should take the opportunity to review the patient in person and if it was the Junior Doctor who requested the ECG (as it was in Mrs. Ellett's case) it is considered that it is that Junior Doctor who should have the opportunity of reviewing that ECG, thus giving continuity of care to the patient.

(8) The Staff Nurse in the Clinical Decisions Unit on the night of the 16th / 17th June 2014 was an Agency Nurse who had had no previous experience ever of working in the Emergency Department or a Clinical Decisions Unit. She was assisted by an experienced Health Care Assistant. However, the Staff Nurse was also working a 12½ hour shift and had had no break until over nine hours into that shift. It is considered that this compromises the care of

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	the Patients in the Clinical Decisions Unit. (9) The Hospital's own Protocol on Observations commends the hands-on approach to the patient which was not the approach used with Mrs. Ellett. (10) The Hospital's own Observation Policy states that if N.E.W.S observations are taken by a Health Care Assistant they should be checked within 30 minutes by the Senior Nurse (in this case the Agency Staff Nurse) who should complete the N.E.W.S scores. This did not happen in Mrs. Ellett's case and thus another opportunity to spend some time with her and review her in person was lost. Each of these points may seem relatively minor taken in isolation, however the accumulative effect when they are all found together as they were in this case is in the view of this Inquest catastrophic.
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 (31st October 2014), namely by **26th December 2014**. I, **Veronica Hamilton-Deeley** 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] 3. [redacted] 4. [redacted] 5. [redacted] 6. [redacted] 7. [redacted], Medico-Legal Services Manager I have also sent it to:- 1. Secretary of State for Health, Department of Health 2. Sir David Nicholson/Simon Stevens - Chief Executive NHS England 3. National Patient Safety Agency 4. [redacted] Director of Public Health 5. [redacted], Director for Clinical Quality and Primary Care Who may find it useful or of interest. 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: 31st October, 2014** **SIGNED BY:** V. Hamilton Deeley **Senior Coroner Brighton and Hove**