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

Assistant Coroners
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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. **Dame Marianne Griffiths, Chief Executive, Brighton and Sussex University Hospitals NHS Trust, Royal Sussex County Hospital, Eastern Road, Brighton** 2. [redacted] **Consultant General & Colorectal Surgeon, Brighton and Sussex University Hospitals NHS Trust, Royal Sussex County Hospital, Eastern Road, Brighton** 3. [redacted] **Deputy Medical Director and Safety and Quality Consultant in Intensive Care and Anaesthetics, Brighton and Sussex University Hospitals NHS Trust, Royal Sussex County Hospital** 4. [redacted] **Head of Medico-legal Services, Brighton and Sussex University Hospitals 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 June 2018 I commenced an investigation into the death of **Kenneth George Alfred WHITTINGTON**. The investigation concluded at the end of the inquest on 6th February 2019.The conclusion of the inquest was **NARRATIVE CONCLUSION – PLEASE SEE ATTACHED SHEET.**
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: – (1) Mr. Whittington's initial operation was abandoned because on his pre operation assessment on the 23rd March 2018 there was no Junior Doctor present. It became apparent that the presence of a Junior Doctor was not imperative by any means. I gather that since this situation occurred and caused a delay in Mr. Whittington's operation the presence of a Junior Doctor in these circumstances is really no longer required. Although the delay neither caused nor contributed to Mr. Whittington's death it must nonetheless have caused him considerable anxiety and inconvenience. (2) Most importantly post operation 'paperwork' contained no instructions regarding the management of his urinary catheter or how long it was to remain in situ. [redacted] said that he had expected to be in place for at least two weeks post operatively and very likely longer because at the operation he had had to make a bladder repair and therefore did not want to remove the urinary catheter until such time as the bladder had healed. Had he made this requirement clear I have no doubt that this matter would not have come to Inquest. (3) Immediately post operatively Mr. Whittington's epidural became disconnected. He complained of increasing pain over the ensuing night and in spite of this nobody, not even the most senior Nurses, ever checked his epidural!. It was not until some hours later in the early morning that the cause for his increasing pain was ascertained. At that stage his pain control was optimised however, this is not a situation which should have occurred. During his period of increased pain he developed a pneumonia. (4) Following the operation Mr. Whittington's last contact with his Consultant was immediately post operatively. Due to the system operated at the Royal Sussex County Hospital (along with many other hospitals as I understand it) the situation is that the operative surgeon will not see the patient again unless there is some specific reason to do so. Instead the patient will be seen by the on call surgical team for that particular day or part of the day.

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	Mr. Whittington therefore saw a Consultant who did not know him and who did not understand either the condition that Mr. Whittington had come in to hospital with (Colovesical Fistula) or the fact that he needed an operation which had included a bladder repair as I have already pointed out (2 above). The surgeon wanted the urinary catheter to remain in situ for at least two weeks to allow the bladder repair that had been made at Mr. Whittington's operation to heal. This was absolutely crucial and yet no specific instructions were given and the post-operative pathway which was being followed gave very little help in that respect either, save to suggest that the catheter should always be removed early, well prior to discharge. Had there been post-operative instructions and had there been a checklist for the Consultant picking up the ward rounds following the operation, the catheter would not have been removed and Mr. Whittington would not have died. If the Trust is insistent on perpetuating this lack of continuity between the Surgeon and the post-operative Consultant care there must be sufficient handover and sufficient clear instructions from the Surgeon doing the operation as to the post-operative care so as to protect the patient. (5) On the 2nd May Mr Whittington's haemoglobin was low. Mr. Whittington needed and was written up to receive two units of blood on the 2nd May. In fact he received one unit on the 3rd May. There is absolutely no rationale for what happened or exploration thereof. This is unsatisfactory (6) Mr. Whittington was due to be discharged on the 4th May. His discharge documentation which acts as a handover for his Doctors was barely completed and this lack of completion is unacceptable.
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 **7th May 2019**. I, the coroner may extend the period. Your response must contain details of action taken or proposed to be taken, setting

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	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. Secretary of State for Health, Department of Health 5. Simon Stevens, Chief Executive, NHS England 6. Clinical Commissioning Group 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 2019** **SIGNED BY:** V. Hamilton-Deeley **Senior Coroner Brighton and Hove**