Coroner Service
West Sussex, Brighton & Hove

Regulation 28: REPORT TO PREVENT FUTURE DEATHS

NOTE: This form is to be used **after** an inquest.

	REGULATION 28 REPORT TO PREVENT DEATHS **THIS REPORT IS BEING SENT TO:** • **Chief Executive, Integrated Care Board** • **Managing Director, Sussex Medical Chambers** • **Chief Executive, CQC** • **Heath Secretary, Department of Health** • **Hospital Manager, Goring Hall**
1	**CORONER** I am Karen HENDERSON, Assistant Coroner for the coroner area of West Sussex, 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 December 2024 I resumed the inquest into the death of Keith James Hankin. On 4th July 2025 I concluded the Inquest. Mr Hankin was 73 years of age at the time of his death. The medical cause of death given was: 1a Multi-Organ Failure 1b. Sepsis 1c. Optical Urethrotomy 2. Hepatic Cirrhosis Secondary to Non-Alcoholic Steatohepatitis, Coronary Artery Disease I found: On the 8th September 2023 Keith James Hankin was admitted to Goring Hall Hospital, Goring, for an elective surgical optical urethrotomy for long standing urethral strictures. Shortly after the procedure Mr Hankin developed sepsis and was transferred to Worthing Hospital, Worthing later that afternoon. Despite supportive intensive care management Mr Hankin died at the hospital on the 11th September 2023. Failings in the community management, pre-operative assessment, intra-operative and post operative care at Goring Hall Hospital on a background of poor clinical governance of the Community Urology Service (CUS) materially contributed to his death. As a whole there, was a gross failure to provide basic medical attention to Mr Hankin when he was dependent on it. I concluded: Mr Hankin died from a recognised complication of a surgical procedure contributed to by neglect
4	**CIRCUMSTANCES OF THE DEATH** Please see my findings above.

5 CORONER'S CONCERNS

During the course of the investigation my inquiries revealed matters giving rise to concern. In my opinion there is a risk that future deaths could 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. Lack of clinical governance of the Community Urology Service (CUS) by the Integrated Care Board (ICB) who commissioned the service and Sussex Medical Chambers (SMC) who were responsible for providing the service

The Integrated Care Board contracted Sussex Medical Chambers to provide a Community Urology Service through any qualified provider in 2015 and renewed the contract through a competitive tendering process twice subsequently. The ICB used a generic contract supplied by NHS England to contract the service. Neither the ICB nor SMC were able to provide any evidence of robust clinical governance or multi-disciplinary team processes to ensure best practice of urology services from inception to date.

2. Lack of Integration of the Community Urology service with NHS Hospital Urology Services

The CUS provided community-based urology services with non-consultant grade urologists without any oversight or integration with hospital-based consultant led urology services. Whilst there was an opportunity for CUS to refer more complex patients to NHS Hospital Trusts the 'silo' effect of these 2 services was such that they effectively worked independently of each other. The absence of a robust multidisciplinary team assessment within the CUS and the lack of senior clinical oversight of community urology patients by NHS consultant clinicians leads to a concern that the urology service is fragmented and does not effectively support urology patients within the region to confirm best practice and optimal treatment.

3. Lack of appraisal and mandatory assessment of clinicians employed by CUS

There was an absence of any appraisal and/or mandatory assessments within the CUS or the ICB and SMC for the associate specialist clinicians who were working extra-contractually outside of their NHS work. No evidence was provided as to their experience and competency. This gives rise to a concern that their working practices are insufficiently assessed and fails to fulfil GMC 'good practice' guidelines. Likewise, no evidence was provided regarding regular morbidity and mortality reviews of complications by the ICB, CUS and SMC such as when patients re-present to NHS hospitals with complications arising from the CUS.

4. Practicing Privileges within the private sector

[redacted] set up and led the CUS under the auspices of SMC. The ICB contractually required this service to be run by a consultant urologist. [redacted] had not held a formal consultant urologist position within the NHS prior to tendering for this work. It remains unclear as to how [redacted] was provided with practicing privileges at a private hospital as a consultant and was therefore able to practice independently and without scrutiny. This gives rise to a concern that there is a lack of robust assessment and guidelines, both locally and nationally, as to how clinicians are given practicing privileges to work independently outside of the NHS to the potential detriment of patient care. It also gives rise to a concern that patients are not being fully informed of the relevant experience of such clinicians thereby breaching the statutory duty of candour responsibility of all hospitals.

	5. Learning from Mr Hankin's death The ICB did not independently review the circumstances of Mr Hankin's death to confirm if there was any learning or changes in practice to prevent further deaths. Likewise, SMC relied on [redacted] to inform them and investigate Mr Hankin's death without considering the inherent conflict of interest in so doing. The lack of an independent review prevented any proactive learning and changes in practice following the death of Mr Hankin. This gives rise to a concern that the system within the ICB and SMC are insufficiently robust and could – as it was with Mr Hankin – prevent transparency and openness as to the circumstances of his death and limit any learning and or necessary changes in practice to prevent future deaths. 6. Management of Mr Hankin at Goring Hall Hospital There were multiple omissions in the pre-operative, intra-operative and post operative care provided by Goring Hall Hospital which individually and collectively contributed to Mr Hankin's death. This included a failure to recognise Mr Hankin underlying medical co-morbidities rendered him unfit to have his operative procedure at the hospital. More specifically the post-operative assessment and support provided by the consultant anaesthetist and surgeon led to a delay in assessing and diagnosing sepsis and thereafter giving appropriate and timely antibiotics and facilitating an earlier transfer to the NHS Hospital for further management. This gives rise to a concern that there was a lack of understanding by the senior clinicians (in the absence of any local and national guidelines provided at the inquest) requiring them to remain responsible for the care of patients throughout their time in a private hospital rather than delegating the care to a Resident Medical Officer who is more likely than not to be insufficiently experienced in managing such critical situations.
6	**ACTION SHOULD BE TAKEN** In my opinion action should be taken to prevent future deaths and I believe that the people listed in paragraph one 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 November 14th 2025. 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: [redacted] Interim Chief Executive, University Hospitals Sussex Chief Medical Officer, University Hospital Sussex [redacted], Sussex Medical Chambers [redacted] Consultant Anaesthetist - Worthing Hospital [redacted] – Consultant Urologist, St Richards Hospital [redacted] – Consultant Urology Lead – University Hospitals Sussex (West) [redacted] – Consultant Urology Lead – University Hospitals Sussex (East) I am also under a duty to send a copy of your response to the Chief Coroner and all interested persons who in my opinion should receive it.

	The Chief Coroner may publish either or both in a complete or redacted or summary form. They may send a copy of this report to any person who they believe 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.
	Dated: 17/09/2025  Karen HENDERSON Assistant Coroner for West Sussex, Brighton and Hove