Penelope A Schofield
Senior Coroner
County of West Sussex

033022 27100
01243 753644 (fax)
hm.coroner@westsussex.gov.uk
www.westsussex.gov.uk

Coroner's Office
West Sussex Record Office
Orchard Street
Chichester
West Sussex
PO19 1DD

30th July 2013

St Richard's Hospital
Western Sussex Hospitals NHS Trust
Spitalfields Lane
Chichester
West Sussex
PO19 6SE

Dear Madam

RE: INQUEST INTO THE DEATH OF PHILLIP ARTHUR PRATT

On the 16th July 2013 I concluded an inquest into the death of Phillip Pratt. The inquest hearing began on 18th June 2013 and was adjourned to the 16th July when it was concluded. In holding this inquest I sat as Assistant Deputy Coroner for the County of West Sussex.

The medical causes of Mr Pratt's death were bilateral bronchopneumonia and metastatic prostatic carcinoma, fracture of the neck of femur and ischaemic heart disease.

The sudden deterioration in his health immediately prior to his death was attributed to the onset of bronchopneumonia following an operation for a fracture to the neck of femur incurred as a result of a fall. The verdict that was returned was "accidental death".

At the conclusion of the Inquest I announced that it was my intention to make a report to the Trust under Rule 43 of the Coroners (Amendment) Rules 2008. This rule provides that where the evidence at an inquest gives rise to a concern that circumstances creating a risk of other deaths will occur or will continue to exist in the future, and in the Coroner's opinion, action should be taken to prevent the occurrence or continuation of such circumstances, or to eliminate or reduce the risk of death created by such circumstances, the Coroner may report the circumstances to a person who may have the power to take such action.

Summary of the facts

Mr Pratt passed away on the 2nd of November 2012 at approximately 0030 hours at St Richards Hospital.

In June/July 2012 he had suffered a fall at home which led to tests being conducted. Those tests revealed a prostrate carcinoma. As part of his ongoing treatment, on the 25th October 2012 Mr Pratt was admitted to St Richards Hospital for elective surgery to insert stents into both kidneys. Pre-operative assessment raised concern as to the weakness in his legs. Although that

assessment meant the elective surgery could not proceed at that point in time, Mr Pratt remained in hospital for further investigations to be conducted. The initial concerns were whether there was a compression of the spinal cord caused by the cancer.

Mr Pratt was admitted initially on a short stay basis for surgery that did not in fact proceed, he then remained in hospital for further tests and thereafter his health had declined to such an extent that he could not be discharged from hospital in any event.

The evidence received during the inquest revealed the following matters:

(a) Mr Pratt began to show signs of confusion on the 26th October 2013 and that led to a rapid decline in his awareness. The onset of confusion may have been due to the prescription of tramadol given to him at the hospital, although it may also be due to other factors which include withdrawal from alcohol consumption. Tramadol was withdrawn on the 28th October and a detoxification program was started. By that stage, Mr Pratt was in a significantly confused state;

(b) He suffered 5 falls at hospital which were recorded in falls forms. Those falls all occurred between the 26th and 29th October 2012;

(c) X-rays taken on the 29th October revealed the fracture to the neck of femur from the last fall which occurred on that day and also a possible fracture to the shoulder believed to be caused during the fall at 0045am on 28th October;

(d) Due to staffing levels, one to one care was not available although it had been requested. Mr Pratt was in a location close to the nursing station where he could be observed. The last fall occurred when a nurse had been away from her station for a matter of minutes;

(e) An operation to address the fracture to the hip was conducted on of the lungs;

(f) His levels of awareness and the state of his confusion seemed to have improved after his operation on the 30th October;

(g) His health declined very rapidly and unexpectedly after 11pm on

Matters of Concern

During the course of the inquest, [redacted], Head of Nursing for St Richards Hospital, gave evidence in relation to a "Root Cause Analysis Investigation Report". The stated purpose of the report was "To identify the root causes and key learning from an incident and use this information". The report covered a number of areas of concern arising from the investigation. [redacted] gave

evidence to say that a number of practices and additional training have already been put in place to address some of the issues set out in the report.
The matters of concern that I raise herein deal with issues raised in the report in respect of which I understand action has not yet been taken.

The matters of concern I raise are as follows:

(1) On admission to hospital and at pre-assessment stage, there was a note of the patient's medication but no note as to dosage of medication. The Report indicates no attempts were made to contact the patient's GP or family to ascertain precise levels of medication;

(2) As it was not expected the patient would remain at hospital for a protracted stay, the need for alcohol detoxification was not considered at an early stage and not reassessed when the reason for the patient's admission changed;

(3) The onset of agitation and confusion had been recognized, with a

(4) There was a delay in discontinuing the prescription for Tramadol despite the onset of confusion which is one of the contra-indications of that medication;

(5) There was a delay in x-raying the shoulder. The report comment

(6) Requests were made for nurse special staff to monitor a high risk patient but extra staff were not available.

In my opinion action should be taken in order to prevent the risk of future deaths and I believe your organisation has the power to take such action.

You are required to respond to this letter within 56 days of the date of this report, namely by the 1st October 2013. If you are unable to reply within this time, you may apply for an extension. The response must contain details of action taken or proposed to be taken, setting out the timetable for such action.

If no action is to be taken, you must explain why no action is proposed.
A copy of this report is being sent to the Chief Coroner and to [redacted] who was identified as an interested person at the inquest.

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 at the time of your response, about the release or the publication of your response by the Chief Coroner.

Yours sincerely,

Elisabeth Bussey-Jones

Assistant Coroner for West Sussex