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

The Manager
Fairlight Nursing Home
121 Worthing Road
Rustington
West Sussex
BN16 3 LX

Dear Sir/Madam,

RE: INQUEST INTO THE DEATH OF DEREK EDWARD BARTLETT TWIVEY

On the 18th July 2013 I concluded an inquest into the death of Derek Twivey. In holding this inquest I sat in Worthing as Assistant Deputy Coroner for the County of West Sussex.

The medical causes of Mr Twivey's death were bilateral subdural haematomas. I set out the circumstances leading to Mr Twivey's death below. 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 Nursing Home 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 Twivey had had a history of a number of admissions to hospital prior to November 2012.

He was further admitted on the 27th November to the Beckett Ward at Worthing Hospital. He was transferred to the Buckingham Ward on the 29th November. On the 16th December he suffered a fall at hospital. As he had sustained a head injury a CT Scan was requested. The scan performed that day showed no signs of bleeding and the findings were similar to the results of scans carried out in October 2012. The Doctor treating him on the Buckingham Ward felt a diagnosis of dementia could not be made at that time.

On the 22nd December 2013 he was discharged from Worthing Hospital to the Fairlight Nursing Home as part of a 'step down' program. Prior to his transfer, a

full assessment had been conducted at Worthing Hospital by [redacted] on behalf of the Nursing Home. The assessment was conducted to consider suitability of the placement, bearing in mind Mr Twivey's needs. It was appreciated at the time that he was a patient with a high falls risk.

He arrived at Fairlight Nursing Home on the afternoon of Saturday, 22nd December. Between 530am on the 23rd December 2012 and 430 am on the 24th December 2012, Mr Twivey suffered 5 falls at the nursing home. The fall at 530am on 23rd December resulted in him being found on the floor with tear to his right ear. At 2050 hours on Sunday 23rd December he was again found on floor with the wound to his ear having re-opened. Later that day at 2330 hours he was found on the floor bleeding again from the same location.

On Monday 24th December [redacted] the registered manager for the Nursing Home, had concerns as to whether Fairlight was a suitable location for Mr Twivey. I understand she had not been on duty over the weekend. She contacted his Community Psychiatric Nurse but did not manage to get through to them at that time. In evidence [redacted] indicated concerns as to suitability of accommodation probably arose on Sunday 24th December. It had been anticipated that a risk assessment should have been conducted within 24 hours of Mr Twivey arriving at the Nursing Home. From the evidence heard it would appear this did not occur because it was a weekend and there was a pressure on staffing levels due to the time of year.

On Tuesday 25th December, Mr Twivey was readmitted to Worthing Hospital. He was noted to have left sided weakness. A CT Scan performed showed subdural haematomas. This was described as a new finding. He remained in Worthing Hospital and passed away there on the 16th of January 2013. He was 91 years of age.

Matters of Concern

During the course of the inquest my enquiries revealed matters giving rise to two areas of concern. Those matters are as follows:

(a)The need to carry out a risk assessment within 24 hours regardless of staffing levels or time of year; and

(b)The timeliness of steps to be taken if it is appreciated shortly after admission that the accommodation is not suitable for the patient's needs.

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