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

Assistant Coroners
CATHARINE PALMER LL.B (HONS)
MICHAEL KEEN
KAREN HENDERSON, BSC,BM,MRCPI,FRCA
GILVA D.J.TISSHAW, BA(LAW)HONS

THE CORONER'S OFFICE
WOODVALE, LEWES ROAD
BRIGHTON
BN2 3QB

Telephone: Brighton (01273) 292046
Fax: Brighton (01273) 292047

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. **Matthew Kershaw Chief Executive, Brighton & Sussex University Hospitals, Royal Sussex County Hospital, Eastern Road, Brighton.** 2. **Nurse / Matron in Charge of Level 9A** 3. **Nurse in Charge of all Nursing at the Hospital** 4. **Chief Pharmacist with regard to the MAR (Medical Administration Records) Charts** 5. **Dr. in charge of A & E** 6. **[REDACTED] – Consultant General Surgeon RSCH**
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 **8th April 2014,** I commenced an investigation into the death of **MARTIN ARNOLD HILL**. The investigation concluded at the end of the inquest on **8th August 2014** .The conclusion of the Inquest was – **A Narrative Conclusion –** [REDACTED]
4	**CIRCUMSTANCES OF THE DEATH** **Please 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.

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	The **MATTERS OF CONCERN** are as follows. – (1) **Although this man arrived in A & E on the 28th March 2014 at approximately 12:30, having been suffering confusion, abdominal pain and vomiting for some three days with raised white cell count and markedly raised C-Reactive Protein. He was not commenced on antibiotics until over 48 hours later at 14:00 hours on the 30th March, 2014. At Inquest I was told that he should have been commenced on Pragmatic antibiotics shortly after his arrival and assessment by a Doctor in A & E.** (2) **At 20:00 hours on the 28th March 2014 after he had been admitted to The Royal Sussex County Hospital, Brighton his NEWS rose from 1 to 6. NEWS' own Guidance and the Hospital's Protocol require that Mr. HILL should have been referred to the Critical Care Outreach Team. He was not. His NEWS rose to 6 again on the 30th March 2014 at 00:20 hours, However, he was not referred then either. He was not referred to Critical Care Outreach until his NEWS rose to 10 at 07:00 hours on the 30th March 2014.** (3) **Whilst it is noted that Mr. HILL was admitted at lunchtime on a Friday and the critical events took place over a weekend, nonetheless he was known to be an intravenous heroin user on a Methadone prescription and yet he was given no treatment for withdrawal treatment save for 2mg of Diazepam on the 28th March at 22:15 hours and another 2mg of Diazepam at 09:00 on the 30th March. Also on the 30th March PABRINEX was considered and he was written up for this, although this was not given. On the 30th March at 09:50 hours he was given 5ml of METHADONE and later at 13:00 on the 30th March he was given another 5ml of Methadone. (*NB: His daily Methadone prescription was 50ml)*** (4) **When Mr. HILL arrived in A & E it was found that he was suffering from constipation with impacted faeces in his bowel. He was written up for an enema and the Doctor who saw him directed that he should be given laxatives. The latter were never written up for him and the former was never given. In the event, careful study of the notes showed that he opened his bowels for the first time on the evening of the 28th March 2014 but this information was not apparently noted by the Doctors who were still talking about constipation over the next 24 – 36 hours. This shows poor patient handover and poor communication between the shifts and poor note taking.** (5) **There are serious omissions on the Medical Administration Record. I was told that it was believed that no Senior Pharmacist reviewed the MAR charts over a weekend. Given the importance of medicating patients correctly, it would seem advisable that there should be a review, if indeed it is the practice that records are not reviewed. It seems that in this particular case the charts are particularly poorly written and perhaps those involved with this patient would benefit from a discussion with the Chief Pharmacist.**
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.

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7	**YOUR RESPONSE** You are under a duty to respond to this report within 56 days of the date of this report (22/8/2014), namely by **17th October 2014**. 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 Interested Persons 1. Family members of the late Mr. Martin Arnold Hill:- [redacted] – .... Sister [redacted] – .... Daughter [redacted] – .... Daughter [redacted] – .... Brother 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) Care Quality Commission (5) [redacted] – Medico Legal Services Manager Royal Sussex County Hospital, Eastern Road, Brighton, BN2 5BE. Who may find it useful or of interest. 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: 22nd August, 2014 SIGNED BY:** V. Hamilton-Deeley **Senior Coroner Brighton and Hove**