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

Assistant Coroners
[redacted]

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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.*

	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO:** 1. **Matthew Kershaw Chief Executive, Brighton & Sussex University Hospital NHS Trust** 2. [redacted] **– Head of Safety Brighton & Sussex University Hospital NHS Trust** 3. [redacted] **– Medico Legal Services Manager, Brighton & Sussex University Hospital NHS Trust** 4. **Nurse in Charge of Twineham Ward, Princess Royal Hospital, Lewes Road, Haywards Heath, RH16 4EX**
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 1st December 2014 I commenced an investigation into the death of **MR. ANTHONY GEERTS** The investigation concluded at the end of the inquest on **10th June 2015**.The conclusion of the inquest was that :- **Tony GEERTS died of pneumonia following an accidentally fractured left neck of femur in circumstances to which neglect at Princess Royal Hospital contributed.**
4	**CIRCUMSTANCES OF THE DEATH** 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. The **MATTERS OF CONCERN** are as follows. – Mr. GEERTS went to Princess Royal Hospital to Twineham Ward (the Ward which specialise in

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	Rehabilitation patients coming from The Royal Sussex County Hospital in Brighton). Mr. GEERTS came with a fractured neck of femur which had been timeously operated. He was determined to return home to his wife who depended on him. He lived in Brighton and Hove and was disappointed to be going to Haywards Heath for rehabilitation as he knew how difficult it would be for his family to visit so regularly. In Brighton he had received physiotherapy and been regularly reviewed. **In Haywards Heath he was effectively abandoned from the 6th**. His notes give no clue as to how he was cared for. His physiotherapy notes end abruptly with no plan. I was told nurses on this rehabilitation ward had been asked to look after him as (a) There was insufficient physiotherapy staff to do so and (b) Without any or any effective consultation, the decision had been made that he was to be discharged to Highgrove Nursing Home as soon as possible after the 6th. Neither Mr. GEERTS nor his family were involved in this decision. Mr. GEERTS had suffered long term mental health issues. These were ignored during his stay at Princess Royal Hospital. His anxieties were not addressed in any meaningful way. He was given no assistance after the 6th. Having been told he was to be transferred for further rehabilitation, Mr. GEERTS remained very anxious about the impending move and about the lack of communication and particularly the lack of physio. For reasons unexplained satisfactorily to this day, he was moved out of Twineham Ward late on the 10th. Bailey Ward was unaware of his needs. He was incontinent of urine. On the 11th he was transferred to the discharge ward from where he contacted his daughter 3 times. He arrived in a poorly state at Highgrove in the mid afternoon. This resulted in him being unable to participate fully in any of the Highgrove activities, nor could he settle in. He was back at The Royal Sussex County Hospital on the 16th with Hospital Acquired Pneumonia and ? urinary tract infection. No more physiotherapy was possible and in spite of ongoing treatment he deteriorated to his death on the 21st. Specifically at Princess Royal Hospital: • Notes not completed. • No nursing notes and no NEWS for 10th or 11th • Fluid chart not completed. Fluid restriction not properly documented. Fluid restriction effectively disregarded. • No plan for physiotherapy • No rehabilitation on Rehabilitation Ward from 6th -10th. Exercise on the 10th not properly documented. • No proper notes or Rationale for transfer to Bailey Ward on 10th/11th. Transfer procedure not followed. Transfer not documented. • No referral of lack of urinary continence. Therefore no plan regarding this. • Failed Trial without catheter on 3rd November 2014. • Bowel monitoring chart not complete • Discharge planning non-existent or inadequate • Communication with patient and family virtually non-existent • No senior review from 4th November 2014; possibility of chest infection not followed up. • Should have had a blood test as requested on 11th November 2014. Did not and therefore unnecessary extra 48 hours on fluid restriction. • Discharge lounge information incorrect.
6	**ACTION SHOULD BE TAKEN**

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	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 **10th September 2015**. 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. [redacted] 2. [redacted] 3. [redacted] 4. [redacted] – Chair of Brighton & Sussex University Hospitals 5. Secretary of State for Health, Department of Health 6. [redacted] – Chief Executive NHS England 7. National Patient Safety Agency 8. [redacted] – Director of Public Health 9. [redacted] – Director of Clinical Quality 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: 24th June 2015.** **SIGNED BY:** [redacted] **Veronica HAMILTON-DEELEY** **Senior Coroner Brighton and Hove**