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

Assistant Coroners
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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.*

	THIS REPORT IS BEING SENT TO: 1. **Dame Marianne Griffiths, Chief Executive, Brighton and Sussex University Hospital NHS Trust.** 2. **Dr Rob Haigh, Medical Director, Brighton and Sussex University Hospital NHS Trust.** 3. [redacted] **Chief Nurse, Brighton and Sussex University Hospital NHS Trust.** 4. **Dr George Findlay, Deputy Chief Executive Officer, Brighton and Sussex University Hospital NHS Trust.** 5. [redacted] **Chairman, Brighton & Sussex University Hospital NHS Trust**
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 July 2019 I commenced an investigation into the death of **Jean Evelyn WAGHORN** The investigation concluded at the end of the inquest on 15th October, 2019.The conclusion of the inquest was a Narrative Conclusion:- **Mrs. WAGHORN died of pneumonia which developed when she was in hospital receiving conservative care for fractures to her neck sustained when she fell at home and hit her head on the floor. This lady was transferred between hospitals three times in just over 48 hours.** **I FIND that the first transfer late on 23rd June 2019 (the day of her fall) was appropriate - she had been diagnosed with a fractured neck at Haywards Heath Local hospital and needed assessment and care at the South East Trauma and Spinal Centre in Brighton.** **I FIND that the next two transfers were not appropriate. I cannot say that they**

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	contributed to her death however she developed the pneumonia from which she died within 2 ½ hours of her arrival back in Brighton on the 25th June. This was quickly recognised and appropriately treated. Sadly however, Mrs. WAGHORN did not make a recovery. She died peacefully on 29th June 2019.
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: – (1) Unnecessary and inappropriate transfers between the Royal Sussex County Hospital, the Princes Royal Hospital and the Royal Sussex County Hospital. (2) The Brighton and Sussex University Hospital NHS Trust policy for transfer was effectively ignored. (3) I have made two recent previous regulation 28 reports concerning the Transfer Policy on 12 July 2018 and 20 July 2018. The response to the former included the assurance that a trust wide transfer policy working group was convened, led by [redacted], three extra assessment tool sheets were created. None of these were used for Mrs Waghorn. Why not? What is the point of the Regulation reports if the trust ignores them?
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.
7	**YOUR RESPONSE** You are under a duty to respond to this report within 56 days of the date of this report, namely by 17th January 2020. 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**

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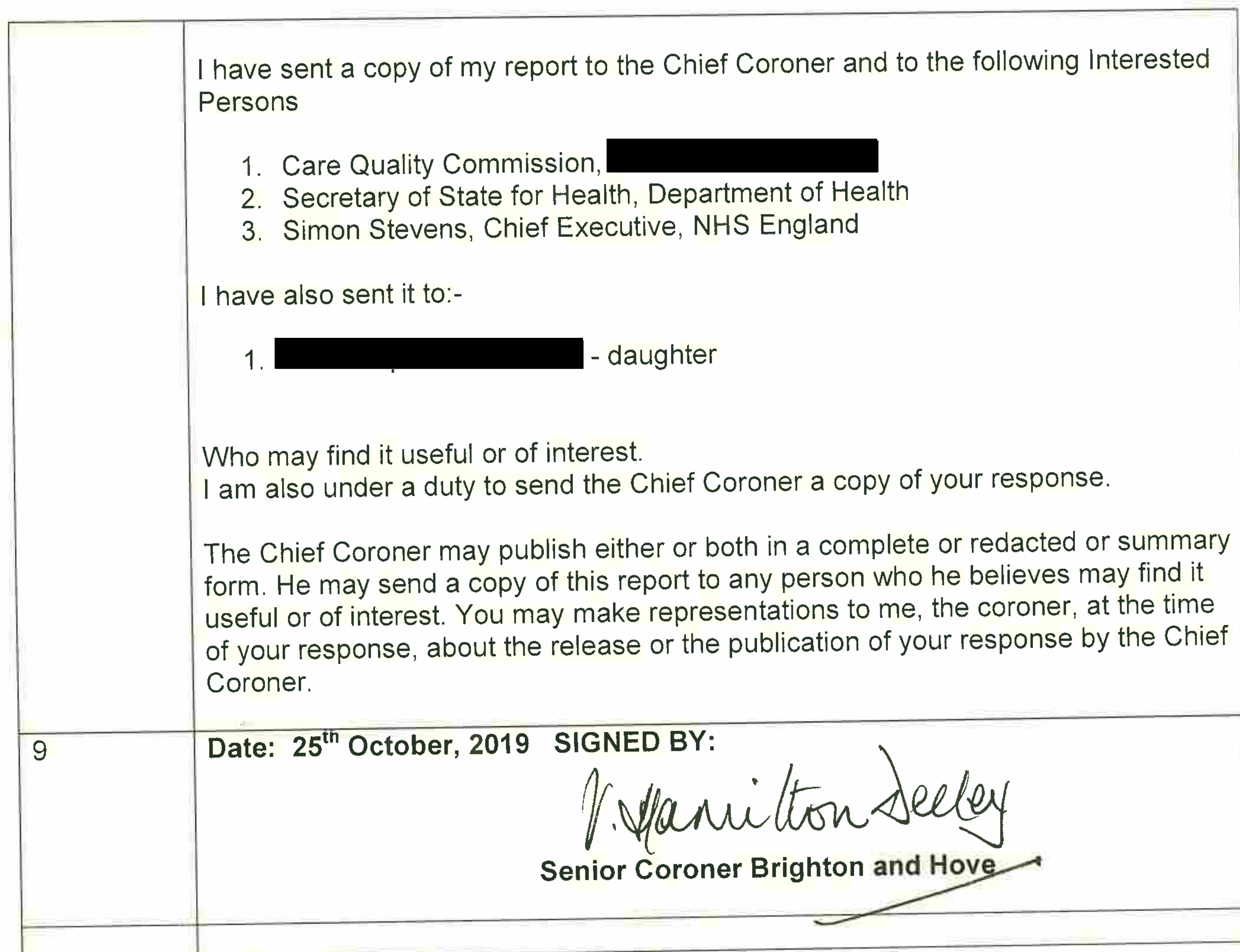

	I have sent a copy of my report to the Chief Coroner and to the following Interested Persons 1. Care Quality Commission, [redacted] 2. Secretary of State for Health, Department of Health 3. Simon Stevens, Chief Executive, NHS England I have also sent it to:- 1. [redacted] - daughter Who may find it useful 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: 25th October, 2019 SIGNED BY:** V. Hamilton Deeley **Senior Coroner Brighton and Hove**