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

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

Assistant Coroners
CATHARINE PALMER LL.B (HONS)
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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. Chief Executive Officer of Brighton and Sussex University Hospital NHS Trust 2. Brighton and Sussex University Hospital NHS Trust 3. Chief Nurse Brighton and 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 29 th July 2019 I commenced an investigation into the death of Mrs Frances Jean Gibb. The investigation concluded at the end of the inquest on 27 th November 2019. The conclusion of the inquest was a Narrative Conclusion as per the attached sheet.
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) Once again I must write concerning the serious failings in the use of NEWS. Please see the Record of Inquest for details. When you respond to this Regulation 28 report will you please explain why it is that I

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	regularly send you reporte on the misuse of NEWO Assistance in the
	regularly send you reports on the misuse of NEWS. Am I to assume that no lessons are being learnt?
	(2) There was a failure to identify a mesenteric thrombus (see Record of Inquest) This appears to have occurred when the junior radiologist was working overnight and under pressures. What lessons have been learned from this?
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 26 th February 2019 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. Local CCG
	 Secretary of State for Health, Department of Health Simon Stevens, Chief Executive, NHS England
	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: 10 th December 2019 SIGNED BY:
	V. Janiton seeley
	Senior Coroner Brighton and Hove