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

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.*

	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO:** **1. Amanda Fadero, Chief Executive, Brighton and Sussex University Hospitals NHS Trust, Royal Sussex County Hospital, Eastern Road, Brighton**
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 12th June 2015 I commenced an investigation into the death of Marion Rose HOWES. The investigation concluded at the end of the inquest on 3rd February 2016.The conclusion of the inquest was a NARRATIVE CONCLUSION – Please see 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

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	(1) Discharge summaries from the hospital These need to be sent electronically to the GP on the day of discharge for continuity of care and full handover to the community from the acute hospital. In addition, the patient must understand the significance and be given his or her copy so that if by any chance there is a delay or a sudden readmission the patient understands the significance of keeping his copy with him for a few days after discharge. (2) At this Inquest I was told that hospital was not considered the best place to impart the difficult news of a cancer and that this is dealt with by a Outpatients appointment being sent for the patient to meet the surgeon and the specialist nurse. In this particular case the patient died and in fact never knew the date of the appointment allocated, but the appointment of the specialist nurse, when the diagnosis is made, would be helpful and timeous and enable the patient to understand and prepare for what is to come. It seems to me that it would be a very much kinder way to proceed and would also mean that the sensible patient would be preparing him or herself for the surgery which is likely to follow. (3) In Mrs. Howes' case there was a complete lack of co-ordination and continuity of care for her. Nobody took charge of her. Nobody was responsible and responsible for liaising with all the relevant firms so that she was dealt with comprehensively and by the appropriate people. It is suggested that consideration be given to the patient being appointed a named Consultant (not one who is just about to go on holiday) from the day of first admission and this Consultant should understand his or her duties with regard to the managing of the patient and ensuring that they are referred on to the appropriate forms and that the multi-disciplinary and multi-agency discussions take place. (4) In Mrs. Howes' case there were two failed discharges. The Trust's discharge policy is excellent on paper, but unfortunately does not appear to be practiced, or wasn't in Mrs. Howes case. I am told that there are new principles entitled 'Right care, Right place Every time'. This is all well and good but frankly if the Trust and those working in it followed their own guidance they would not need to constantly revisit perfectly good polices. It was clear from the Inquest that the discharge form should begin to be completed from the very beginning of the patient's 'journey'. Here it wasn't. It seems to me that this form should include two extra sections. First – ask whether there has been a failed discharge within the last X days and secondly address the question of whether this patient is a complex patient who should be dealt with under the complex guidance. I understand that that is not available at weekends, and so presumably complex patients should not be discharged at weekends or bank holidays. (5) There was a failure to recognise the fact that Mrs. Howes was dying. Those looking after her over the last two or three days of her life may have felt under pressure from a demanding family, but families have a right to be demanding as do patients, and doctors and nurses should be able to manage their expectations. The failure to recognise that Mrs. Howes was dying resulted in an undignified and uncomfortable death for her and an enduring and sad memory for her family.
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, namely by 29th April 2016 . 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. Secretary of State for Health, Department of Health 2. Sir David Nicholson/Simon Stevens – Chief Executive NHS England 3. National Patient Safety Agency 4. [redacted] 5. Clinical Commissioning Group 6. [redacted] – Director of Pulbic Health 7. [redacted] – Chair of BSUH NHS Trust 8. [redacted] – Director for Clinical Quality and Primary Care I have also sent it to:- 1. [redacted] 2. [redacted] 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.
	Date: 11 · 2 · 16 **SIGNED BY:** V. Hamilton-Deeley **Veronica HAMILTON-DEELEY** **Senior Coroner Brighton and Hove**