VERONICA HAMILTON-DEELEY, 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)
MICHAEL KEEN
KAREN HENDERSON, BSC,BM,MRCPI,FRCA
GILVA D.J.TISSHAW, BA(LAW)HONS

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.*

	THIS REPORT IS BEING SENT TO: **1. [redacted], Chief Clinical Officer, Clinical Commissioning Group** **2. [redacted], Interim Chief Executive, Brighton and Sussex University Hospital Trust** **3. Zoe Nicholson, Chief Executive, Brighton and Hove Integrated Care Service**
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 **17th February 2016** I commenced an investigation into the death of Geoffrey John MOYSE. The investigation concluded at the end of the inquest on 17th February 2016.The conclusion of the inquest was Medical Misadventure.
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.

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

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

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

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

The **MATTERS OF CONCERN** are as follows. –

(1) Please see the attached letter dated the 19th December 2014 which explains the system which was put in place by the CCG.

Please refer to Part 3 of the attached Record of Inquest to learn what happened in Mr Moyse's case.

It is clear to me from the evidence I heard at the Inquest that there was a huge delay in referring him (its right to say that some of that delay was due to Mr Moyse being unable to help speed the process up). Nonetheless, it took eight months from referral to seeing the appropriate Surgeon and I should imagine a referral direct to Digestive Diseases would have been substantially quicker than that.

There was no understanding it seems by the people involved in the arrangements that it was probably possible to try and short circuit them. For example, why did the Consultant Gastroenterologist not contact the colo-rectal clinic himself or even copy his letter and his histology report sent to the GP on the 29th June 2015?

Why did BICS, who were sent a copy of the histology report, not forward this to anyone else e.g. the colo-rectal clinic to see whether it would produce the urgent result which the GP was seeking to achieve?

Could the GP have done a two week referral at the very beginning? Would that have come within Code 2 on the letter of the 19th December 2015? If he had, perhaps the whole system would have worked.

One of the problems in existence appears to be that because the initiative involves private hospitals, some private hospitals will use their own histo-pathologists to analyse results of procedures such as colonoscopies instead of using the National Health laboratories. This means that the results do not automatically feed in to the local NHS system. Surely it would be possible to insist that all x-ray results, MRI scans, CT scans, histopathology reports etc. etc. which arise in this way as part of an NHS initiative involving the private sector must be transmitted back into the NHS system at the earliest possible opportunity.

VERONICA HAMILTON-DEELEY, 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)
MICHAEL KEEN
KAREN HENDERSON, BSC,BM,MRCPI,FRCA
GILVA D.J.TISSHAW, BA(LAW)HONS

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

	It just seems to me that this system broke down because these processes seem to work without any reference to a joined up approach and the person who suffers is the patient. In this case I was eventually satisfied that this did not adversely affect the outcome with Mr Moyse but certainly it meant that the whole process for him was hugely delayed and he was left unwell, undiagnosed and untreated for far, far too long. I would like to see a complete review of this process and I am sure that Mrs Moyse would be happy, suitably anonymised, if Mr Moyse's case could be used to ensure that this does not happen again to another patient where this delay might have been fatal on its own.
	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 13th May 2016. I, **Veronica HAMILTON-DEELEY,** 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] 5. Secretary of State for Health, Department of Health 6. Simon Stevens – Chief Executive NHS England 7. National Patient Safety Agency 8. Care Quality Commission 9. [redacted] Director of Public Health 10 [redacted] Director for Clinical Quality and Primary Care 11 [redacted] – Medico Legal Services Manager

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

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

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

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

	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: 19th February 2016** **SIGNED BY:** V Hamilton Deeley **Senior Coroner Brighton and Hove**