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

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

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

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. SECAMB** **2. Brighton and Sussex University Hospitals NHS Trust**
1	**CORONER** I am Gilva Dagmar Jane Tisshaw Assistant 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 3rd March 2016 I commenced an investigation into the death of Ronald William Bennett . The investigation concluded at the end of the inquest on 10 February 2017.The conclusion of the Inquest was a short narrative as set out on the attached document.
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) There are serious delays in ambulances arriving at the scene of an incident

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	as a consequence of ambulance crews being delayed at the Accident and Emergency department as they are unable to handover patients within the national standard for hospital handovers at A and E of 30 minutes .I heard evidence that on the 20 February 2016, out of 105 patients conveyed to hospital, 91patients were delayed over 30 minutes (95.55%), 2 patients over 120 minutes. The hours lost to handover and turnaround delays from April 2015-January 2017 at the Royal Sussex County Hospital Brighton were 12779.70. (an average of 580.9 per month/19.9 hours a day). (2) Care Quality Commission report published 23.10.2015-urgent - emergency services found to be Inadequate. (3) Reasons for delay in hospital handovers were various involving not only the Accident and Emergency department but the inability of the hospital to admit patients because of lack of availability of beds. (4) It should be noted that in respect of Mr.Bennett, that although there was a significant delay in him being admitted to hospital, this did not contribute to his death. (5) It should also be noted that some steps are being taken to address these issues and there is cooperation between SECAMB and the RSCH.
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 working days of the date of this report, namely by 26th June 2017. 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] Head of Legal Services ,Sussex Partnership NHS Foundation Trust.

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	3. Secretary of State for Health, Department of Health 4. Simon Stevens – Chief Executive NHS England 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: 5th April 2017** **SIGNED BY:** **Assistant Coroner Brighton and Hove**