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,FRCA
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. [redacted], **Brighton and Sussex University Hospitals Trust, Royal Sussex County Hospital, Eastern Road, Brighton** 2. **Ms. Gillian Norton, Chief Executive, St. George's University Hospitals NHS Foundation Trust, Blackshaw Road, Tooting, London**
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 Ninth August 2017 I commenced an investigation into the death of Roger Albert Saxby. The investigation concluded at the end of the inquest on Twenty second November 2017. The conclusion of the inquest was Natural Causes to which delay in treatment and lack of urgency contributed.
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.

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	The **MATTERS OF CONCERN** are as follows: – (1) There are basic requirements for staffing and resources for a vascular hub. Royal Sussex County Hospital does not meet these requirements. As a result of this failing it was necessary for Mr Saxby to be transferred to another hub – at Inquest I heard that this was an almost unheard of transfer. It is unacceptable that a vascular hub does not meet the basic requirements and provide the basic resources. I heard that measures are 'in place' for this situation to be remedied, but in my view that is not good enough. There is no guarantee that in a weeks time another Mr Saxby will not appear on a Friday afternoon or evening and require the full resources that he should receive but find they are not available. Resources may be reduced but that is not an excuse for providing unsafe services. In addition, the decision to transfer Mr Saxby to St George's was delayed and on arrival at St George's the start of thrombolysis was also delayed. After Mr Saxby received his thrombolysis at St George's, it became clear that the discussion about what should happen to him next was completely unstructured. None of those involved in his case demonstrated any sense of urgency. There was insufficient discussion with Mr Saxby. Having had one 'most unusual' transfer from hub to hub there was apparently no thought that <u>another</u> 'most unusual' transfer from hub to hub might not be in Mr Saxby's best interest. The essence of the first transfer is to ensure the patient is transferred from spoke to hub speedily so they can receive specialist care in a centre of excellence. There should never need to be a hub to hub transfer and certainly <u>not</u> two of them within 36 hours of each other.
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**

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	You are under a duty to respond to this report within 56 days of the date of this report, namely by 25th February 2018 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] 3. [redacted] 4. British Society of Interventional Radiology 5. Royal Society of Radiologists 6. G4 Patient Transport 7. Secretary of State for Health, Department of Health 8. Simon Stevens, Chief Executive, NHS England 9. Care Quality Commission 10. Clinical Commissioning Group 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: 8th December 2017** **SIGNED BY:** V. Hamilton-Deeley **HM Senior Coroner**