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

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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. Dr Rob Haigh, Medical Director, BSUH** **2. Dr Stephen Drage, Deputy Medical Director and Safety and Quality Consultant in Intensive Care and Anaesthetics, BSUH** **3. Ms Marianne Griffiths, Chief Executive, Brighton & Sussex University Hospitals NHS Trust** **4. [redacted] Chief Nurse BSUH** **5. [redacted] Matron for Old People** **6. [redacted] – Ward Manager for Level 8A**
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 16th March 2018 I commenced an investigation into the death of Ronald Thomas HARMAN. The investigation concluded at the end of the inquest on17TH July 2018 .The conclusion of the inquest was NARRATIVE CONCLUSION.
4	**CIRCUMSTANCES OF THE DEATH** See Record of Inquest (See attached sheets)
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

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	taken. In the circumstances it is my statutory duty to report to you. The **MATTERS OF CONCERN** are as follows: – (1) Brighton & Sussex University Hospitals NHS Trust's Transfer Policy once again ignored. (2) No transfer should take place unless and until it is adhered to. (3) Care at Newhaven Downs suboptimal. Patient deteriorated Returned to Royal Sussex County Hospital with aspiration pneumonia. Died of aspiration pneumonia (unable to respond to/benefit from anti biotics) 8 days later.
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 10th October 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] Daughter of Mr Harman 2. [redacted] Brighton and Hove CCG 3. Secretary of State for Health, Department of Health 4. Simon Stevens, Chief Executive, NHS England 5. David Behan, Chief Executive, CQC I am also under a duty to send the Chief Coroner a copy of your response.

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	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 July 2018** **SIGNED BY:** V. Hamilton-Deeley. **Senior Coroner Brighton and Hove**