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

Assistant Coroners
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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. **Dame Marianne Griffiths, Chief Executive, Brighton and Sussex University Hospitals NHS Trust, Royal Sussex County Hospital, Brighton** 2. [redacted] **Chairman, Brighton and Sussex University Hospital NHS Trust, Royal Sussex County Hospital, Brighton** 3. [redacted], **Medico-Legal Services Manager, Brighton and Sussex University Hospitals NHS Trust, Royal Sussex County Hospital, 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 9th November 2018 I commenced an investigation into the death of **Ioannis AVGOUSTI** The investigation concluded at the end of the inquest on 18th April 2019.The conclusion of the inquest was **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

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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) On the 2nd September 2017 the NICE Guidance for the Diagnosis and Management of Allergy was not followed.
It was suggested to me that following the episode of anaphylaxis on the 27th July 2018 the NICE protocol was followed and therefore lessons had been learned to protect future patients however, I found that that was not the case. Whilst two Mast Cell Tryptase tests had been carried out and there had been some rather sporadic marking of a possibility of allergy in some of the hospital documentation, there had been no proper communication either immediately following the incident or later on within the hospital itself nor to the GP nor to Mr. Avgousti himself or his family. This was simply not good enough.

(2) On the 6th October 2018 although the hospital had noted that he was allergic to Co-Amoxiclav and although the paper medication notes noted that fact he was written up for that medication and it was administered to him.
I saw evidence of a poorly documented, from the point of view of time, NEWS observation. Although at the top of the chart there were the numbers 2 0 (20) I found on the balance of probabilities that this set of observations had more likely been taken at about 20:10 or 20:15 hours.
The observations were added up to 9. In fact the total was 13.
NEWS is a tool to ensure that the deteriorating patient is recognised and given help and escalated, if appropriate, to Intensive Care.
This set of observations was not acted on in accordance with the directions and no escalation was made. There should have been a MET call then i.e., at around 20:15 hours to a specialist registrar (there was one on duty)
If this call had been made and if the appropriate doctor had been called to see Mr. Avgousti it is possible that although the sepsis protocol would I believe have been implemented, it would have been realised that he had an allergy to Co-Amoxiclav and he would have been given an appropriate alternative.
Whilst I cannot say categorically that this would have been the case I believe it is highly likely.
NEWS is an important tool and should not be ignored as it was on Vallance Ward on the night of the 6th October 2018.

(3) On the same night the nurses and the doctors were working 12½ hour "weekend" shifts". The day nursing shift was one nurse short and so far as the doctors were concerned they were, as I understand they always are at weekends, too few in number and as a result all staff in hospital are thoroughly stretched and stressed and under resourced.
This is no way to run a hospital service.
Exacerbating factors in Mr. Avgousti's case were that his rapid deterioration took place at around handover for both doctors and nurses, thus adding even more pressure to the situation.

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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 **12th July 2019**. 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. [redacted]s, Healys Solicitors 5. [redacted], Chair, Clinical Commission Group, Brighton 6. David Behan, Chief Executive, Care Quality Commission 7. Secretary of State for Health, Department of Health 8. 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: 24th April 2019** **SIGNED BY:** V Hamilton Deeley **HM Senior Coroner Brighton and Hove**