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

THE CORONER'S OFFICE
WOODVALE, LEWES ROAD
BRIGHTON
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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. [redacted] Chief Executive Officer, Nuffield Health, London** **2. Matron, Nuffield Hospital, Woodingdean, Brighton** **3. Dr. [redacted] – Consultant orthopaedic surgeon**
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 10th November 2020, I commenced an investigation into the death of **Mr. John Charles LOTT** The investigation concluded at the end of the inquest on **29th April, 2021**.The conclusion of the inquest was a Narrative Conclusion:- **"JOHN LOTT DIED FOLLOWING ELECTIVE SURGERY FOR A DEFUNCTIONING ILEOSTOMY. POST-OPERATIVELY THERE WERE TWO MISSED OPPORTUNITIES TO TRANSFER HIM FROM THE PRIVATE HOSPITAL TO AN ADJACENT HOSPITAL WITH LEVEL 2 AND 3 INTENSIVE CARE FACILITIES. HAD HE BEEN TRANSFERRED WHEN HE SHOULD HAVE BEEN IT IS POSSIBLE THAT THE OUTCOME FOR HIM WOULD HAVE BEEN DIFFERENT."**
4	**CIRCUMSTANCES OF THE DEATH** **John Lott was a 78 year old man who had a procedure to form a defunctioning ileostomy on 21.10.20. Post-operatively there were two occasions (on the 27th and the 29th) when he was sufficiently unwell to require transfer from the**

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	private hospital where he was, to the acute NHS hospital which had the intensive care facilities which I FIND that he needed. He was not transferred on either occasion. He deteriorated rapidly and around the time of transfer, on a background of inadequately treated hypoglycaemia, he suffered myocardial ischaemia and infarction. He did not have the reserves to recover from this and died on 8th November 2020. 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) On 27th October 2020, Mr. Lott's NEWS 2 scores were so high as to require transfer to a hospital with appropriate critical care facilities not available at the Brighton Nuffield. (2) On the 29th October Mr. Lott's hypoglycaemia was not being managed. He should have been transferred. (3) When [redacted] the Consultant "in charge" of Mr. Lott was not immediately available no one appears to have been contacted the on call anaesthetist for input and support. Why not? Is the transfer policy sufficiently highlighted for nursing staff and Resident Medical Officers?
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 **29th July 2021**. 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.

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8	**COPIES and PUBLICATION** I have sent a copy of my report to the Chief Coroner and to the following Interested Persons 1. [redacted] Wife 2. Dr [redacted] 3. [redacted] Head of Quality and Nursing Clinical Commissioning Group 4. Secretary of State for Health, Department of Health 5. [redacted] Chief Executive, NHS England 6. [redacted] - Chief Executive CQC 7. [redacted] – Medico Legal Manager- University Hospitals Sussex NHS Trust Who may find it useful or of interest. 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: 10th May 2021 SIGNED BY:** V Hamilton-Deeley **Senior Coroner Brighton and Hove**