

**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.*

	<p><b>THIS REPORT IS BEING SENT TO:</b></p> <ol style="list-style-type: none"><li>1. Dame [REDACTED] Chief Executive, Western Sussex Hospital Trust</li><li>2. Mr [REDACTED] – Chief of Service, Western Sussex Hospital Trust</li><li>3. Mr. [REDACTED] – Consultant Trauma &amp; Orthopaedic Surgeon</li></ol>
1	<p><b>CORONER</b></p> <p>I am Veronica HAMILTON-DEELEY, Senior Coroner, for the City of Brighton and Hove</p>
2	<p><b>CORONER'S LEGAL POWERS</b></p> <p>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.</p>
3	<p><b>INVESTIGATION and INQUEST</b></p> <p>On <b>12<sup>th</sup> December 2019</b> I commenced an investigation into the death of <b>Linda Ann PHILLIPSON</b> The investigation concluded at the end of the inquest on <b>2nd September 2020</b>. The conclusion of the inquest was</p> <p><b>MEDICAL MISADVENTURE BEING MAJOR PULMONARY EMBOLISM DURING SURGERY FOR A COMPLICATED TIBIAL FRACTURE ON A BACKGROUND OF UNNECESSARY DELAYED EXTERNAL FIXATOR AND SUBOPTIMAL CARE BOTH LEADING TO INCREASED IMMOBILITY BEFORE TRANSFER TO THE SOUTH EAST TRAUMA CENTRE</b></p>
4	<p><b>CIRCUMSTANCES OF THE DEATH</b></p> <p>See Record of Inquest</p>
5	<p><b><u>CORONER'S CONCERNS</u></b></p> <p>During the course of the inquest the evidence revealed matters giving rise to</p>

	<p>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.</p> <p>The <b>MATTERS OF CONCERN</b> are as follows: –</p> <ul style="list-style-type: none"> <li>(1) The delay in applying the external fixator</li> <li>(2) The apparent failure to mobilize the patient</li> </ul>
6	<p><b>ACTION SHOULD BE TAKEN</b></p> <p>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.</p>
7	<p><b>YOUR RESPONSE</b></p> <p>You are under a duty to respond to this report within 56 days of the date of this report, namely by <b>26<sup>th</sup> November 2020</b>. I, the coroner may extend the period.</p> <p>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.</p>
8	<p><b>COPIES and PUBLICATION</b></p> <p>I have sent a copy of my report to the Chief Coroner and to the following Interested Persons</p> <ul style="list-style-type: none"> <li>1. Mr. [REDACTED]</li> <li>2. Brighton &amp; Sussex University Hospital Trust</li> <li>3. Secretary of State for Health, Department of Health</li> <li>4. Simon Stevens, Chief Executive, NHS England</li> </ul> <p>I have also sent it to:-</p> <ul style="list-style-type: none"> <li>1. Dr [REDACTED] – CCG</li> <li>2. Mr. [REDACTED], Head of Quality and Nursing CCG</li> <li>3. Mr. [REDACTED] – Chief Executive CQC</li> </ul> <p>Who may find it useful or of interest.</p> <p>I am also under a duty to send the Chief Coroner a copy of your response.</p> <p>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.</p>

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

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9	Date: 8th September 2020 SIGNED BY:  Senior Coroner Brighton and Hove