VERONICA HAMILTON-DEELEY,
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.*

	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO:** 1. **Mr. Matthew Kershaw, Chief Executive, Brighton & Sussex University Hospitals, Royal Sussex County Hospital, Eastern Road, Brighton** 2. [redacted] **Principal Lead Clinician in Emergency Medicine, Brighton & Sussex University Hospitals, Royal Sussex County Hospital, Eastern Road, Brighton** 3. [redacted] **Chief of Safety & Quality Brighton & Sussex University Hospitals, Royal Sussex County Hospital, Eastern Road, 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 the 22nd July 2013 I commenced an investigation into the death of Stephen John PALMER. The investigation concluded at the end of the inquest on 24th January 2014.The conclusion of the inquest was (see attached Record of Inquest).
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. The **MATTERS OF CONCERN** are as follows. – (1) Delay in being seen both by Nursing Staff and Doctors in A & E. Delay in being seen by Surgical Team after referral to them at 05:30 hours on the 13th July 2013. Delay in ongoing assessment by the Surgical Team when he started to deteriorate and no Surgical Team member was available to respond to the calls for help from the Nursing Staff at the Acute Medical Unit. (2) No early senior review. (3) Inappropriate transfer to an Acute Medical Unit when he should either have stayed in A & E or gone to a Surgical Unit. The concern was that he was effectively unsafe and in an inappropriate clinical environment. (4) There was a failure to appreciate his deterioration largely because he was not seen by the Surgical Team in spite of requests that he should be seen. (5) Even though his acute abdomen had been diagnosed at 07:00 hours there was a failure to appreciate the dangers of his condition. (6) His clinical management was suboptimal. (7) There was a completely inadequate Ward Round Note made at the hurried ward round between 08:30 and 08:40 hours. This left the Nursing Staff in the Acute Medical Unit unable to look after this surgical patient efficiently. (8) Failure to prepare Mr. Palmer for surgery which it had been acknowledged he needed urgently. (9) Failure to arrange an emergency theatre for him (CEPOD). (10) A complete failure of the CT scanning service at this Hospital. This led Mr. Palmer to be denied a CT scan which would certainly have diagnosed his condition. This failure arose because the CT scanning system at this Hospital is unfit for purpose.
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 22nd April, 2014. 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. Secretary of State for Health, Department of Health 4. Sir David Nicholson/Simon Stevens – Chief Executive NHS England 5. National Patient Safety Agency I have also sent it to:- 6. [redacted] – AMU 7. [redacted] – Consultant Vascular Surgeon 8 [redacted] Consultant Colorectal Surgeon 9. [redacted] – Staff Nurse 10. [redacted] – Critical Care Outreach Nurse 11. [redacted] – Lead Consultant Department of Imaging & Nuclear Medicine 12. [redacted] 13. [redacted]

	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: 25th February, 2014 SIGNED BY:** V. Hamilton-Deeley **Veronica Hamilton-Deeley** **Senior Coroner Brighton and Hove**