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

THE CORONER'S OFFICE
WOODVALE, LEWES ROAD
BRIGHTON
BN2 3QB

Telephone: Brighton (01273) 292046
Fax: Brighton (01273) 292047

Assistant Coroners
CATHARINE PALMER LL.B (HONS)
MICHAEL KEEN
KAREN HENDERSON, BSC,BM,MRCPI,FRCA
GILVA D.J.TISSHAW, BA(LAW)HONS

## 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.*

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| | **REGULATION 28 REPORT TO PREVENT FUTURE DEATHS**<br><br>**THIS REPORT IS BEING SENT TO:**<br><br>1. **Mr. Matthew Kershaw Chief Executive, The Royal Sussex County Hospital, Brighton**<br>2. **Head Nurse / Matron – AMU - The Royal Sussex County Hospital, Brighton**<br>3. [redacted] |
| 1 | **CORONER**<br><br>I am **Veronica HAMILTON-DEELEY**, Senior Coroner, for the City of **Brighton and Hove** |
| 2 | **CORONER'S LEGAL POWERS**<br><br>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**<br><br>On **7th May 2014** I commenced an investigation into the death of **LINDA ANNE RIGNALL.** The investigation concluded at the end of the inquest on **4th September 2014.** The conclusion of the inquest was **a Narrative Conclusion.** |
| 4 | **CIRCUMSTANCES OF THE DEATH**<br>[redacted] |
| 5 | **CORONER'S CONCERNS**<br><br>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.<br><br>The **MATTERS OF CONCERN** are as follows. –<br><br>(1) At 17:33 on the 5th May 2014, Linda Rignall's condition changed and this was recorded on the NEWS Observation chart. This change in condition should have been reported to a Doctor on the Acute Medical Unit and she should have been assessed. The position worsened some 4 |

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| | hours later (the next time observations were performed) and there was still no request for a medical review.<br>From the evidence it was clear to me and I found as you will see from the Conclusion that I recorded that this failure to refer Miss Rignall for assessment resulted in the only window of opportunity available to treat her, being lost.<br>This makes me concerned as to AMU's Fitness for Purpose at the current time. I consider this to be serious. |
| 6 | **ACTION SHOULD BE TAKEN**<br><br>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**<br><br>You are under a duty **to respond to this report within 56 days** of the date of this report (19th September 2014), namely by **14th November, 2014**. I, **Veronica HAMILTON-DEELEY** the coroner may extend the period.<br><br>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**<br><br>I have sent a copy of my report to the **Chief Coroner** and to the following Interested Persons<br><br>1. [redacted]<br>2. [redacted]<br>3. [redacted] Quayside Medical Practice, Newhaven<br>4. Secretary of State for Health, Department of Health<br>5. Sir David Nicholson/Simon Stevens – Chief Executive NHS England<br>6. National Patient Safety Agency<br>7. [redacted] Director for Clinical Quality and Primary Care<br>8. [redacted] Director of Public Health<br>9. [redacted] – Medico Legal Services Manager<br><br>I am also under a duty to send the Chief Coroner a copy of your response.<br><br>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 September, 2014 SIGNED BY:**<br><br>V. Hamilton Deeley<br><br>**Senior Coroner Brighton and Hove** |