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

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

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. **Matthew Kershaw, Chief Executive, Brighton & Sussex University Hospitals NHS Trust, Royal Sussex County Hospital, Eastern Road, Brighton** 2. [redacted] **Chief Nurse, Brighton & Sussex University Hospitals NHS Trust, Royal Sussex County Hospital, Eastern Road, Brighton** 3. [redacted] **AMU Manager, Brighton & Sussex University Hospitals NHS Trust, 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 11th August 2015 I commenced an investigation into the death of **Thelma Patricia JONES**. The investigation concluded at the end of the inquest on11th August 2015.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** This report once again, concerns the Acute Medical Unit (AMU) where Mrs. JONES was admitted from the 16th - 23rd February 2015 when she became acutely unwell and was moved to ITU having been intubated on AMU.

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	The two matters which cause me the most concern are:- • firstly the fact that there was very little evidence of any joined up thinking with regard to her care or to plans, either for her future treatment or for her future placement, or for discharge whilst in AMU and I would certainly like to have seen that. • The second matter is once again the question of the National Early Warning System (NEWS), which had been reasonably well completed until we come to the day of her acute deterioration, when after a NEWS score of 8, and a medical emergency team call made at about 09:45 on the morning of the 23rd February 2015, the scoring is not completed. This is extremely poor; it is a matter that I have raised before and **it must, please, be addressed**.
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 30th October 2015. 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 4. [redacted] – Assistant Manager, Medico-Legal Services 5. Secretary of State for Health, Department of Health 6. Simon Stevens – Chief Executive NHS England 7. National Patient Safety Agency 8. [redacted] Department of Health 9. [redacted] – Director of Public Health 10 [redacted] – Director of Clinical Quality 11. [redacted] – Chair of Brighton & Sussex University Hospital. I have also sent it to:- 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

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	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: 12th August 2015** **SIGNED BY:** [redacted] **Veronica HAMILTON-DEELEY** **Senior Coroner Brighton and Hove**