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

Assistant Coroners
CATHARINE PALMER LL.B (HONS)
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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. **Brighton and Sussex University Hospitals NHS Trust, [redacted] Medico-legal Services Manager** 2. **Evelyn Barker, Chief Executive, Brighton and Sussex University Hospitals NHS Trust**
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 12th August 2016 I commenced an investigation into the death of Paul William BARBER. The investigation concluded at the end of the inquest on 24th February 2017. The conclusion of the inquest was a Narrative Conclusion – please 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

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	taken. In the circumstances it is my statutory duty to report to you. The **MATTERS OF CONCERN** are as follows. – (1) Samples being sent to microbiology in the wrong containers and to elaborate on that Mr Barber had a recently diagnosed aggressive lung cancer on the back of which he developed pericarditis. By the 21st July 2016 it was clear that there was a collection of fluid around his heart which was susceptible to draining. This was done and sampling of the fluid was sent to the microbiologists for analysis. However, it was sent in the wrong container, this meant that it needed incubation before it could be dealt with giving a potential delay for results of between 24 – 48 hours. If it had been sent in the correct pot there is a good chance that full results would have been available the same day it was sent as the laboratory is open and testing until 7 p.m. (2) Delay in reporting important results to clinicians. On the 22nd July bacterial growth was detected in the bottles and gram staining showed gram positive cocci – this information was passed to the medical team looking after Mr Barber. On the next day, Saturday 23rd July, the laboratory found the sample growing two organisms. This indicated that Mr Barber had a bacterial pericarditis – this was a very unusual situation and the identification of the organisms ought to have been given on the Saturday as soon as it was known to the medical team. For some reason the organisms were not reported until Tuesday 26th July shortly after Mr Barber's death. Had these results been given appropriately on the 23rd July appropriate steps could have been taken to treat the patient with antibiotics. It is right to say that in this particular case on the balance of probabilities the two failings mentioned above did not affect the outcome – however it is right to report this so that these mistakes are highlighted and do not occur again either in this Hospital Trust or any other.
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 25TH May 2017 I, the coroner may extend the period. Your response must contain details of action taken or proposed to be taken, setting

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	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. Simon Stevens – Chief Executive NHS England 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: 2nd March 2017** **SIGNED BY:** V. Hamilton Deeley **Senior Coroner Brighton and Hove**