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

Assistant Coroners
CATHARINE PALMER LL.B (HONS)
KAREN HENDERSON, BSC,BM,MRCPI,FRC..
GILVA D.J.TISSHAW, BA(LAW)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. Ms Marianne Griffiths, Chief Executive, Brighton and Sussex University Hospitals NHS Trust** **2. [redacted] Brighton and Sussex University Hospitals NHS Trust** **3. [redacted] Brighton and Sussex University Hospitals NHS Trust** **4. Mr K Singh, Clinical Director, Abdominal Surgery and Medicine, BSUH**
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 13th March 2018 I commenced an investigation into the death of Rita Elizabeth GILES. The investigation concluded at the end of the inquest on 5th July 2018. The conclusion of the inquest was NARRATIVE CONCLUSION.
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.

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	The **MATTERS OF CONCERN** are as follows: – (1) Unnecessary transfers to and from the Princess Royal Hospital with no supporting paperwork. (2) The Trust's own Transfer Policy not adhered too in any respect. (3) Delay in her endoscopic retrograde cholangiopancreatography ERCP until she was so ill that it needed to be done on the CEPOD list under general anaesthetic and required ICU support. This lady never recovered from this procedure and died a few days later. (4) At Inquest it was explained to me that there are only three people in the Trust that can carry out ERCP work, they have one list each a week, lists are only on Mondays, Wednesdays and Fridays. The lists seem to be booked well in advance so there is little or no resource for the patient who comes in as Miss Giles did with an urgent requirement. There was a failure to appreciate that as she was already septic when she came in the matter was urgent. From the Inquest it appeared that the Princess Royal Hospital was not the right place for her to be, there is argument to suggest that she should have been transferred early to the Royal Sussex County Hospital in Brighton and presumably if she needed urgent treatment she could have had it. Surely, the lists are designed to accommodate the patients not the other way round.
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 28th September, 2018. 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] Sister of Rita GILES 2. Care Quality Commission

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	3. Clinical Commissioning Group 4. Secretary of State for Health, Department of Health 5. 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: 11TH July 2018** **SIGNED BY:** V Hamilton Deeley **Senior Coroner Brighton and Hove**