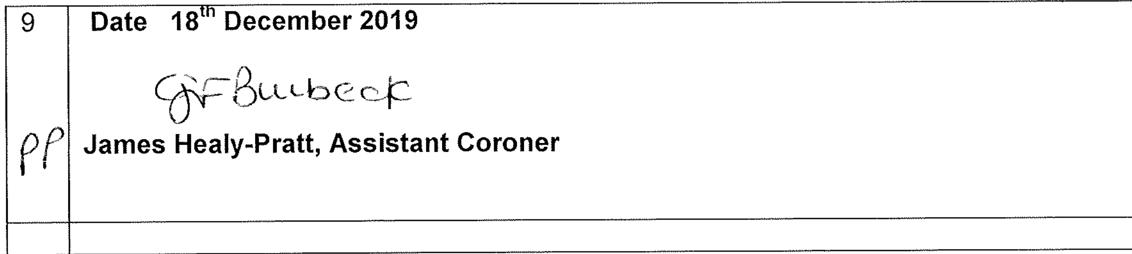
REGULATION 28: REPORT TO PREVENT FUTURE DEATHS

*NOTE This form is to be used **after** an inquest*

	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO: Simon Stevens, The Chief Executive of the NHS**
1	**CORONER** I am **Mr James Healy-Pratt**, assistant coroner, for the coroner area of **WEST SUSSEX**
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** A seven day Article 2 Jury Inquest was completed on 12th December 2019 into the death of Suzanne Roberts
4	**CIRCUMSTANCES OF THE DEATH** Miss Roberts was detained as patient under the Mental Health Act, at The Dene, a private hospital in West Sussex She died on 18th October 2015 at the Dene, from sudden cardiac arrest arising out of Acute Kidney Injury, Pyelonephritis, Chronic Dehyrdation and an underlying condition of a High Output Stoma Miss Roberts had significant physical healthcare issues arising from her High Output Stoma, which together with other self-harming behaviours, resulted in her admission to the Royal Sussex County Hospital ("RSCH") in Brighton, East Sussex, on several occasions during her seven week stay at The Dene Her last admission to the RSCH was on 12th October 2015, where she was found to have high potassium and Acute Kidney Injury Due to systems and communications failings between different Departments at the RSCH and within the Department of Trauma and Orthopaedics, Miss Roberts was discharged on 14th October 2015, without knowledge of her initial admission, renal assessment and recommended in-patient treatment, but with blood test results that showed high levels of potassium, which led to heart failure and death on 18th October 2015 The Jury found that there had been neglect The Jury made factual findings a) That there was fragmented information sharing between Departments at the RSCH, resulting in a serious failure to be aware of this patient's needs b) There was not an effective system in place at the RSCH for the use of this patient's clinical records c) There was not an effective system in place at the Truama and Orthopaedic Department at the RSCH for ths use of this patient's clinical records d) There was not effective communication between all Departments at the RSCH and within the Department of Trauma and Orthopaedics at the RSCH relating to treatment of Suzanne Roberts And that these probably contributed and caused her death on 18th October 2015

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 A Senior Consultant at the RSCH gave evidence at the Inquest in December 2019 and described the current system of managing patient records at the RSCH as "sub-optimal" and "flawed" and that a similar death to that of Suzanne Roberts could occur (in the same circumstance as seen in October 2015) in December 2019 The Jury found the management of patient records at the RSCH to be ineffective, as was cross Department communication in relation to patient treatment The Jury also found ineffective communication and ineffective use of patient records within the Department of Trauma and Orthopaedics in relation to patient treatment Whilst there was evidence that £30m had been recently spent by the Brighton and Sussex Universities Hopsital NHS Trust on a failed attempt to create a single electronic patient record, the Inquest revealed that There were at least three software systems in use by different Departments at RSCH, alongside paper records, and that a portal system, Panda, was also partially in place In the absence of mandatory rules for the use of those systems or portal, and mandatory quality assurance about data uploaded to those systems or portal, there is a continuing risk of future deaths due to ineffective management of patient records and ineffective communication across departments at RSCH
6	**ACTION SHOULD BE TAKEN** In my opinion action should be taken to prevent future deaths and I believe 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 12th February 2020 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 - - Father of Suzanne Roberts - Legal Representative for The Dene Legal Representative for Ms Prowse - Legal Representative for Brighton and Sussex University Hospital – Brighton and Sussex University Hospital 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 18th December 2019** **James Healy-Pratt, Assistant Coroner**