

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:
	 Chief Executive Brighton Sussex University NHS Hospital Trust & West Sussex NHS Hospital Trust West Sussex NHS Hospital Trust Dr Brighton Sussex University NHS Hospital Trust Cc Medico-Legal
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 30 th October 2020 I commenced an investigation into the death of Mr. Brian David BUTTON The investigation concluded at the end of the inquest on 12th February 2021. The conclusion of the inquest was MEDICAL MISADVENTURE
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.
	The MATTERS OF CONCERN are as follows: -

	(1) That on 29 th October 2020 Catharine James Ward at The Royal Sussex county Hospital in Brighton contained 13 beds. These beds are not socially distanced. A patient safety review confirms this. Mr. Button contracted COVID-19 pneumonitis on Catharine James Ward. Whilst patients on the ward now have to wear masks (on a respiratory ward!) and there is much more regular and faster testing the beds are still not socially distanced. In October there were 13 beds in the ward. As at today's date (12 th February 2021 there are still 13 beds in the ward.
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 14 th May 2021 . 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
	 Son Dr Head of Quality and Nursing Clinical Commissioning Group Secretary of State for Health, Department of Health Chief Executive, NHS England Chief Executive CQC.
	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 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.

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

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

9	Date:	19th February 2021 SIGNED BY:	
		Senior Coroner Brighton and Hove	