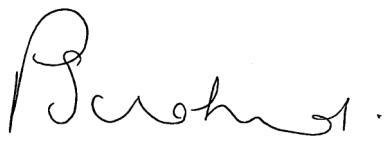
Regulation 28: REPORT TO PREVENT FUTURE DEATHS

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

	REGULATION 28 REPORT TO PREVENT DEATHS **THIS REPORT IS BEING SENT TO:** **1 NHS England & NHS Improvement (reg 28 reports)**
1	**CORONER** I am Penelope SCHOFIELD, Senior Coroner for the coroner area of West Sussex, 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 24 August 2021 I commenced an investigation into the death of Nicholas John PENNICOTT aged 61. The investigation concluded at the end of the inquest on 19 April 2023. The conclusion of the inquest was that: On 19th August 2021 Nicholas, who was suffering from Guillain Barre Syndrome, suffered a cardiac arrest at his home address. Nicholas' health had been deteriorating and at the time of his death he had been waiting over 8 weeks to see a neurologist following an urgent referral. This delay had caused him additional stress and anxiety. The conclusion of the Inquest was that Nicholas had died from natural causes.
4	**CIRCUMSTANCES OF THE DEATH** Mr PENNICOTT's health had been deteriorating since March 2021 and this resulted in an admission to A&E at St Richards Hosptial on 23rd June 2021. Following this admission Mr PENNICOTT was referred to see a Neurologist , as an urgent referral, as an outpatient. At the time he was suffering from Guillain Barre Syndrome. Despite his GP and family chasing up this appointment he was not offered an appointment until 19th August 2021. Sadly he suffered a cardiac arrest in the early hours of the very day that his appointment was due to take place.
5	**CORONER'S CONCERNS** During the course of the investigation my inquiries revealed matters giving rise to concern. In my opinion there is a risk that future deaths could occur unless action is taken. In the circumstances it is my statutory duty to report to you. The **MATTERS OF CONCERN** are as follows: During the course of the evidence the Hospital explained that long waiting times for neurology outpatient appointments was a persistent challenge for the Trust due to capacity issues within the neurology service. There had been a long-term vacancy, of three years, within the neurology service for a substantive neurology consultant at the hospital. The Inquest was told that there was a

	national shortage of neurologists. The Trust had relied on long term locum consultants, leading to some short-term gaps in provision. The shortage of Neurologists nationally and the capacity issues within the neurology service at the Hosptial led to a missed opportunity for Mr PENNICOTT to receive earlier specialist assessment.
6	**ACTION SHOULD BE TAKEN** In my opinion action should be taken to prevent future deaths and I believe you (and/or 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 July 04, 2023. 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 [redacted] [redacted] [redacted]**, CEO, University Hospital Sussex NHS Trust** [redacted]**, CEO, Astra Zeneca** [redacted] **CEO, MHRA** I have also sent it **Association of British Neurologists** who may find it useful or of interest. I am also under a duty to send a copy of your response to the Chief Coroner and all interested persons who in my opinion should receive it. I may also send a copy of your response to any person who I believe may find it useful or of interest. 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	**Dated: 11/05/2023** 

	Penelope SCHOFIELD **Senior Coroner for** **West Sussex, Brighton and Hove**