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

Assistant Coroners
CATHARINE PALMER LL.B (HONS)
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. The Chief Executive, Brighton & Sussex University NHS Hospital Trust** **2. Director of Safety** [redacted] **3. Assistant Director of Safety -** [redacted] **4. Nurse Director,** [redacted] **5. Chief Nurse,** [redacted] **6. Clinical Director,** [redacted] **for Facilities and Estates**
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 **14th November 2017** I commenced an investigation into the death of **Mrs. Joan Catherine BLABER.** The investigation concluded at the end of the inquest on **20th September 2018.**The conclusion of the inquest was as per the attached **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) Historic and ongoing failure to comply with Control of Substances Hazardous to Health Regulations (COSHH) (2) Failures in training (both Trust and Agency Staff) and in particular to ensure that training has been understood and retained. (3) Confusion in roles. Mixing the roles of the cleaners with those members of staff who should only be dealing with food and water. (4) Failure to communicate important practices/protocols eg. water jug system. (5) Failure in training and post training monitoring for Trust staff and lack of control over training for agency staff using hazardous substances. (6) Failures in supervisory staff in the housekeeping department (particularly those on the fourth floor of the Thomas Kemp Tower) to adhere to their own practices and requirements eg. Giving Agency Staff a container of Flash to take away. Blatent breach of COSHH (7) Failure to encourage reporting of suboptimal and dangerous practices within the hospital. (8) Failure to identify "near miss" events, to disseminate these and to learn from previous mistakes.
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 18th December, 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**

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	I have sent a copy of my report to the Chief Coroner and to the following Interested Persons 1. [redacted] Blaber 2. [redacted] 3. [redacted], Sussex Police 4. [redacted], Sussex Police 5. [redacted], Healy's Solicitors 6. [redacted], Medico-Legal Head, 7. Care Quality Commission 8. Secretary of State for Health, Department of Health 9. [redacted], Chief Executive, NHS England 10. National Patient Safety Agency 11. Clinical Commissioning Group - [redacted] 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:** **1st October 2018** **SIGNED BY:** V. Hamilton-Deeley **Senior Coroner Brighton and Hove**