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

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

Telephone: Brighton (01273) 292046
Fax: Brighton (01273) 292047

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. [redacted], Brighton and Sussex University Hospitals Trust, Royal Sussex County Hospital, Eastern Road, Brighton.** **2. [redacted] Head of IT, Brighton and Sussex University Hospitals Trust, Royal Sussex County Hospital, Eastern Road, Brighton**
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 Fifteenth June 2017 I commenced an investigation into the death of **Paul Eric GANDER**. The investigation concluded at the end of the inquest on Twenty seventh November 2017. The conclusion of the inquest was a **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) That at a weekend and out of hours the Consultant Orthopaedic and Trauma Surgeon involved was not able to access the electronic records of other departments within the hospital. This is completely unacceptable. This information is imperative. Arrangements must be made to ensure that full access is given to properly authorised personnel to all hospital records.
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 **25th February 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] 2. [redacted], Solicitor 3. Secretary of State for Health, Department of Health 4. [redacted], Chief Executive, NHS England 5. Care Quality Commission 6. Clinical Commissioning Group 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.

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9	**Date: 8th December 2017 SIGNED BY:** V. Hamilton Deeley **Senior Coroner Brighton and Hove**