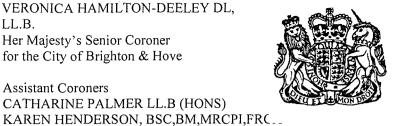
VERONICA HAMILTON-DEELEY DL, LL.B. Her Majesty's Senior Coroner for the City of Brighton & Hove

CATHARINE PALMER LL.B (HONS)

GILVA D.J.TISSHAW, BA(LAW)HONS

Assistant Coroners



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

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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.

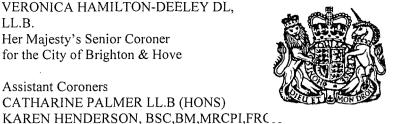
·	THIS REPORT IS BEING SENT TO:
	1. NHS Foundation Trust, Swandean, Arundel Road, Worthing. BN13 3EP
1	CORONER
	I am Veronica HAMILTON-DEELEY, Senior Coroner, for the City of Brighton and Hove
2	CORONER'S LEGAL POWERS
	I make this report under paragraph 7, Schedule 5, of the Coroners and Justice Act 2009 and regulations 28 and 29 of the Coroners (Investigations) Regulations 2013.
3	INVESTIGATION and INQUEST
	On 17 <sup>th</sup> June 2016 I commenced an investigation into the death of Trevor John CURRY. The investigation concluded at the end of the inquest on 17 <sup>th</sup> March 2017 .The conclusion of the inquest was a Narrative Conclusion – see attached sheet.
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.

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

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The MATTERS OF CONCERN are as follows. -(1) It is nationally acknowledged that there are a growing number of patients in both acute and psychiatric hospitals and prisoners who have substantial mental health and physical problems. This is particularly the case in view of the ageing hospital and prison population. It is therefore incumbent upon those caring for such people to ensure that they have full mental and physical past medical histories. In this particular case at Inquest, I accepted that the deceased's sister had informed the triaging and admitting staff at the psychiatric hospital of the fact that he was being seen by the Cardiologist and was suffering with heart problems (i.e. palpitations). No note was made of this in Mr Curry's admitting note. It should have been. In addition, the psychiatric trust made no effort to ascertain his full past physical history until after he had died. Of course they were not expecting him to die within 48 hours of admission but that is not the point. Enquiries of this nature should be made at the earliest opportunity and if there are no reciprocal IT arrangements then the individual trusts must have arrangements between them so that they can access appropriate history speedily. This is particularly important in cases where a patient is admitted to a psychiatric hospital in an agitated, even psychotic state and unable to give an appropriate history him or herself. **ACTION SHOULD BE TAKEN** 6 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 9<sup>th</sup> June 2017. 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. 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

Assistant Coroners CATHARINE PALMER LL.B (HONS) KAREN HENDERSON, BSC,BM,MRCPI,FRC GILVA D.J.TISSHAW, BA(LAW)HONS Telephone: Brighton (01273) 292046 Fax: Brighton (01273) 292047

8	COPIES and PUBLICATION
	I have sent a copy of my report to the Chief Coroner and to the following Interested Persons
	<ol> <li>Head of Legal Services, Sussex Partnership NHS Foundation Trust</li> <li>Secretary of State for Health, Department of Health</li> <li>Generation - Chief Executive NHS England</li> <li>Sussex Partnership Trust</li> <li>Millview Hospital</li> </ol>
	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: 17 <sup>th</sup> March 2017 SIGNED BY: <i>N.Manilin Jeeley</i> Senior Coroner Brighton and Hove