Coroner Service
West Sussex, Brighton & Hove

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 Surrey and Sussex Healthcare NHS Trust**
1	**CORONER** I am Joanne ANDREWS, Area 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** Mr Marriott elected to undergo a haemorrhoidal artery ligation with mucopexy surgery following consultations with his surgeon. He underwent a pre-assessment for the surgery on 30 March 2024 which was conduced by telephone using the assessment on the Surrey and Sussex Healthcare NHS Trust Cerner system. During the assessment he was asked about his family medical history and his own history of haematological conditions. He was not asked about his family history of haematological conditions directly as this is not required by the system. The evidence to the Court was that the clinicians relied upon the patient's response to their family medical history question to ascertain this. The evidence was that Mr Marriott was aware of his significant family history of blood clotting disorders. The evidence from clinicians who assessed him was that this was not disclosed to them. The family believe that he did make this known but there is no evidence which indicates when, where or to whom this was made. The evidence was that he had not been directly asked about this and it was not stated on his notes or GP documentation. On 12 April 2025 he underwent the haemorrhoidal artery ligation with mucopexy surgery as a day patient. He was given compression stockings as per the Trust guidance as well as mechanical calf compression during the procedure which was above what the guidance required. On 15 April 2024 he sadly died at home. A post mortem found he died due to a Pulmonary embolism which on the evidence was a result of the surgery.
4	**CIRCUMSTANCES OF THE DEATH**
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: The evidence was that the system which is used for assessment of patients prior to day surgery does not (a) directly require a question to be asked about their haematological family history or (b) record negative answers to the questions related to the patient's own haematolgical history
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 September 4, 2025. 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: The family of Mr Marriott I have also sent it to Moatfield Surgery 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. She may send a copy of this report to any person who she 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: 09/07/2025 J. Andrews Joanne ANDREWS Area Coroner for West Sussex, Brighton and Hove