

REGULATION 29 RESPONSE TO A REPORT ON ACTION TO PREVENT FUTURE DEATHS

Please do not include any living person names in this document, in accordance with the Chief Coroner's [publication policy PDF](#).

THIS RESPONSE IS BEING SENT TO:

The Area Coroner, Mr Joseph Turner for the Coroner Area West Sussex, Brighton and Hove in response to a '**REPORT TO PREVENT FUTURE DEATH REGULATION 28**' following an investigation into the death of **Mary FORLIN**, and an inquest that concluded on **09 December 2025**.

RESPONDENT

In line with our duty under Regulation 29 of the Coroners (Investigations) Regulations 2013, **[REDACTED], Chief Executive of University Hospitals Sussex NHS Foundation Trust** provides this response within 56 days of the date of the Report to Prevent Future Deaths or any extension granted.

DATE OF RESPONSE: 27 July 2026

CONFIRMATION OF CORONER'S MATTERS OF CONCERN

The **MATTERS OF CONCERN** were identified in the report are as follows:

I recognise and acknowledge the actions taken by the Trust with regard to the timeframe and speed with which an unidentified infection may be addressed by antibiotic medication.

Notwithstanding the existence of guidance, recommending review at 48-72 hours, and noting that this remains a live discussion topic at the Trust's training sessions, it was apparent from the evidence heard, that clinicians did not actively consider or appear to follow the guidance, despite blood tests showing continuing signs of infection which broad spectrum antibiotics had not reduced. Nor were microbiology tests ordered early on when antibiotics had had no immediate effect; a missed opportunity confirmed in the evidence heard and which the medical witness suggested could, with hindsight, have been considered.

Underlying these events, however, it is apparent that current policies, systems and processes – including electronic records – do not proactively flag, up, drive or require active consideration of tests, including whether and when results have been obtained, or whether further specialist tests should then be required, enabling more timely consideration as to whether targeted antibiotics should be administered, at urgency and pace where a patient remains patently unwell.

Accepting that other actions iterated in the Trust's recent submissions will reduce the risk of similar future deaths, there appear to be no obvious systemic checks and failsafes in patient care as regards infection testing, treatment and then review –

especially where treatment is not working.

I am acutely aware that where action has been taken, a 'PFD' report may be otiose, but in this case my concern persists, notwithstanding the action taken, and nor do I consider that resource grounds significantly preclude further action. I also consider, given the obvious and welcome development of the Electronic Patient Record, that there remains a realistic prospect of some action being taken by which that system flags up, alerts and or far more proactively drives clinical assessment and review, where infection markers persist.

I duly consider there remains a risk of further deaths, and that further action should be taken to reduce the risk of death in such circumstances, fully accepting that it is not possible to eliminate that risk entirely.

DETAILS OF ACTION TAKEN

University Hospitals Sussex NHS Foundation Trust confirm:

Systems in place within the Microbiology Department to identify patients with infection, critically ill with infection, those at risk of or already deteriorating, ones with significant positive cultures, those that need changes to treatment or initiation and those that need discussion with regards to investigations or further microbiological samples:

- Any particularly significant positive microbiology (mainly blood cultures/cerebral spinal fluid [CSF], but also others, such as urines, stool, wound/prosthetic joint, eye, sputum or resistant organisms) are telephoned out directly to the clinical teams by medical staff. The discussion includes a full history, further investigations required, and an ongoing management plan with regards to infection.
- There is a daily bench round by microbiologists within the lab, where significant results are highlighted and discussed.
- The duty Microbiologist and Registrar will review patients face to face as part of the bacteraemia round (positive blood cultures that are significant or CSF positive cultures) or if there are patients that require infection consult assistance: very unwell, not responding, complex, diagnostic challenge or deteriorating clinically.
- Direct patient reviews at the Princess Royal Hospital on Tuesdays and Fridays.
- Microbiology have regular Multidisciplinary Team (MDT) meetings for patients admitted to different specialities: Monday - Burns and Plastics at Queen Victoria Hospital (QVH), Neurosurgery, Shoulder/Elbow MDT (monthly), ICU (Intensive Care Unit) ward round; Tuesday - ICU ward round, Diabetic foot infection (monthly), Neonatal, Endocarditis, Ortho-plastics, Respiratory, Wednesday - Bone/Joint infection MDT, OPAT (outpatient parenteral antimicrobial therapy) virtual round for patients on IV (intravenous) antibiotics in the community, Vascular MDT, ICU round, HIV MDT; Thursday - Cardiothoracic MDT, ICU ward round, Paediatric MDT, Plastics and Maxillofacial MDT QVH; Friday - ICU ward

round, Renal MDT, Endocarditis MDT.

- Patients with complex infections, difficult to treat, deteriorating, positive cultures are discussed or seen at these MDTs.
- Microbiology have a bleep and telephone system during routine hours and 24/7 on-call to discuss patients with infection (in hospital or in the community), results from cultures, IPC (infection prevention and control) issues, patients at risk of clinical deterioration, raised inflammatory markers (with unclear cause), and general infection queries.
- Clinical teams looking after the patients (in hospital or in the community) consider infection / follow up results that are available on ICE (integrated clinical environment) IT system.
- There are 500-750 positive microbiology results generated/day that are authorised on our electronic WinPath laboratory system and available to all clinicians on ICE.

DETAILS OF FURTHER ACTION PROPOSED

The Trust's EPR (electronic patient record) implementation is underway and continues. The Trust is completing key groundwork required now, for example data migration, Wi-Fi upgrades, and process alignment and training and testing. The EPR implementation in 2027 will make it easier to capture information in patient records and to find it when it is needed and share with all of those involved in their care.

The Trust has a closed loop reporting (CLR) application at St Richard's Hospital and Worthing Hospital which automatically 'pushes' investigation results electronically directly to clinicians and enables clinicians to acknowledge the results of radiological and histopathological results and act on them. The CLR system also includes dashboards which allow visualisation of reports that have not yet been acknowledged. Replicating the ability to acknowledge receipt of results is within the scope of the EPR. This functionality will be complementary to contact between those delivering care and other specialists with relevant subject matter expertise and rolled out to the Royal Sussex County Hospital and the Princess Royal Hospital.

Delivering the greatest benefits with clinical decision support (CDS) requires mature data, careful design and collaboration between digital teams and clinicians. Clinical decision support is included in phase 3 of our EPR implementation.

SIGNATURE

