REPORT TO PREVENT FUTURE DEATHS
REGULATION 28 OF THE CORONERS (INVESTIGATIONS) REGULATIONS 2013

Please do not include any living persons' names in this document, in accordance with the Chief Coroner's PFD Publication Policy (2026).

1.	**CORONER** I am Joseph TURNER, Area Coroner, for the coroner area of West Sussex, Brighton and Hove.
2.	**DATE OF REPORT** 05 June 2026
3.	**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.
4.	**THIS REPORT IS BEING SENT TO** The Chief Executive, University Hospitals Sussex NHS Foundation Trust You are under a duty to respond to this report within 56 days of the date of this report, namely by July 31, 2026. I, the coroner, may extend the period if an appropriate application is made.
5.	**YOUR RESPONSE** 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. I have a duty to send a copy of your response to the Chief Coroner. In accordance with the Chief Coroner's Publication Policy, you should send me any representations regarding publication of your response. These representations should be made at the same time as the response is provided. I will pass any representations received to the Chief Coroner for a decision. Please note any links to webpages included in the response will not be checked for sensitive information prior to publication, as the information is already online. The names of those who do not respond to PFD reports are regularly published on the Chief Coroner's webpages Non-responses to Prevention of Future Death (PFD) reports - Courts and Tribunals Judiciary.
6.	**SUMMARY OF CORONER'S CONCERN** Whilst recognising the prime importance of clinical judgment, my concern is that there is no proactive, or an insufficiently rigorous, system or process –

	potentially driven by the electronic patient record – by which tests, including microbiology, for patients with serious infections are ordered, assessed and/or chased, so as to enable a more rapid and targeted approach when broad spectrum antibiotics have failed to improve a patient's condition.
7.	**ACTION SHOULD BE TAKEN** In my opinion unless action is taken to address the above concerns then there is a significant risk of future deaths and I believe each of you have the power to take such action.
8.	**INVESTIGATION AND INQUEST** Mrs Mary (also known as Moira) Forlin died in the Royal Sussex County Hospital, Brighton, on 28th July 2024. Her death was referred to the Coroners Service on 8th August 2024. There was then a lengthy and detailed investigation as to whether her death should proceed to inquest. The inquest was eventually opened on 24th July 2025. The inquest was heard, including live evidence from a Geriatric Consultant, on 9th December 2025. Further time was then afforded to the Interested Persons to provide legal submissions as to whether the duty to issue a Prevention of Future Deaths report under Paragraph 7 of Schedule 5 of the Coroners and Justice Act 2009 arose. Regrettably, there was an internal administrative delay within that latter timescale such that this report is only now being issued, following receipt and consideration of submissions from the family and Trust.
9.	**CIRCUMSTANCES OF DEATH** Mrs Forlin was admitted to hospital as an emergency on 21st July 2024 following a fall at home with a long lie. She was suffering from respiratory failure, likely driven by an infection. The source was never identified and antibiotic treatment did not resolve this over an extended period. Microbiological analysis was not undertaken. Fluids were administered and attempts made to balance organ support, with occasional low level overload. She remained at high risk throughout admission. At around 1030 on 27th July Mrs Forlin suffered a sudden collapse with lowering of oxygen and blood pressure and increased heart rate. The immediate medical cause of the collapse could not be identified, but despite emergency treatment she remained unresponsive. Treatment continued until it was agreed to no longer be in her best interests. She sadly died the following morning from multiorgan failure arising from infection of unknown source and respiratory failure.
10.	**CORONER'S CONCERNS** During the course of the inquest I heard evidence 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: 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.
11.	**COPIES AND PUBLICATION OF THIS REPORT** I have a duty to send a copy of my report to every Interested Person who in my opinion should receive it. I also may send a copy of the report to any other person who I believe may find it useful or of interest. I can confirm I have sent the report to: Those members of the family who attended the inquest. I also have a duty to send a copy of the report to the Chief Coroner.

	You may make representations to me, the coroner, about the publication of the contents of this report in line with Chief Coroner's PFD Publication Policy (2026). Any representations will be sent to the Chief Coroner alongside the report. Please refer to box 4 above for additional information relating to the publication of reports and responses.
12.	**SIGNATURE**  **Joseph TURNER** **Area Coroner for** **West Sussex, Brighton and Hove**