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 Senior Coroner, Penelope Schofield 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 **Gemma Louise ROBINS**, and an inquest that concluded on **06 July 2026**.

1.	**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.
2.	**DATE OF RESPONSE 28 August 2026**
3.	**CONFIRMATION OF CORONER'S MATTERS OF CONCERN** The **MATTERS OF CONCERN** were identified in the report are as follows: There was a failure to identify at an antenatal appointment that a blood pressure reading for a pregnant woman, in her third trimester (36 weeks) was showing signs of mild hypertension. Therefore no further checks were carried out and the patient left without urine analysis having been undertaken which I understand to be basic routine steps required to check for possible preeclampsia. There was no evidence of any adequate safeguard in place to ensure that these basic checks are carried out at these antenatal appointments.
4.	**DETAILS OF ACTION TAKEN,** University Hospitals Sussex NHS Foundation Trust confirm: Communication regarding the importance of urinalysis and actions to be taken when a raised blood pressure is found has been shared with the maternity staff via the Maternity Message of the Week. This has been reinforced with the 'Every Urine Sample Matters' poster, displayed in the antenatal clinics, DAU (Day Assessment Unit), MAU (Maternity Assessment Unit), and Community team facilities. The Antenatal Care guideline has been updated to reflect the importance of

	urinalysis.
5.	**DETAILS OF FURTHER ACTION PROPOSED** An anonymised summary of Gemma's case will be used in multidisciplinary mandatory training within the next annual programme, which is attended by all maternity staff, to highlight the importance of basic observations, including urinalysis, at every appointment. A Documentation Audit is within the Maternity targeted audit programme for financial year 26/27. The proforma for the audit is still under review before the audit is launched but is being planned to include whether the correct observations have been completed and the correct escalation has taken place if abnormal findings are made.
6.	**SIGNATURE**  **Chief Executive**