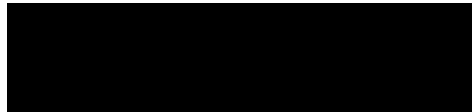
VERONICA HAMILTON-DEELEY DL,
LL.B.
Her Majesty's Senior Coroner
for the City of Brighton & Hove

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



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. **[REDACTED] - Chief Executive, University Hospitals Sussex NHS Foundation Trust** 2. **A&E Clinical Lead at Princess Royal Hospital and Day Surgery Unit (Twineham Ward) - University Hospitals Sussex NHS Foundation Trust** 3. **[REDACTED] – Assistant Manager, Medico-Legal, University Hospitals Sussex NHS Foundation Trust**
1	**CORONER** I am **Veronica HAMILTON-DEELEY**, Senior Coroner, for the City of Brighton & 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 23rd November 2020 I commenced an investigation into the death of **Janet WILLCOCK.** The investigation concluded at the end of the inquest on 31st March 2021. The conclusion of the inquest was "**RECOGNISED COMPLICATION (NAMELY STROKE) OF APPROPRIATE SURGERY FOR CRITICAL AORTIC STENOSIS.**"
4	**CIRCUMSTANCES OF THE DEATH** Mrs Willcock was a lady of 61 years who was diagnosed with critical aortic stenosis and bicuspid valve following emergency admission to Royal Sussex County Hospital with chest pains on 28th October 2020. She was optimised for surgery which took place as soon as it could on 17th November 2020. She had some post-operative bleeding and this was dealt with in a return to theatre the next day. On the 19th November Mrs Willcock suffered a major stroke. This was identified and treated in accordance with stroke protocols but, sadly, she died on 21st November

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	2020. On 12th August 2020 Mrs Willcock had an episode of syncope, fell and fractured her wrist. She was taken to A & E at Princess Royal Hospital. On 28th August 2020, the fracture was fixed. On neither occasion was there evidence that her chest was auscultated. If it had been I FIND from the evidence that her heart murmur would have been heard. This failing represented a missed opportunity to diagnose and treat her aortic stenosis earlier. However, I am satisfied that this did not change the outcome for Mrs Willcock.
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. The **MATTERS OF CONCERN** are as follows: – On 12th August 20 Mrs Willcock presented at A&E, Princess Royal Hospital having fainted and fallen. (1) She had a head injury and a fractured wrist. There is no evidence that her chest was auscultated. (2) On the 28th August 2020 Mrs Willcock attended for day surgery (fixation of her wrist fracture). Again, there is no evidence that her chest was auscultated. (3) The evidence I heard informed me that if it had been a new heart murmur it would have been heard which, taken with the syncope, should have resulted in an immediate referral to Cardiology.
6	**ACTION SHOULD BE TAKEN** 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 **30th June 2021**. I, Veronica Hamilton-Deeley, the Senior 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.

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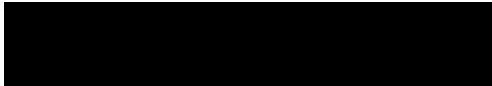

8	**COPIES and PUBLICATION** I have sent a copy of my report to the Chief Coroner and to the following Interested Persons 1. Son 2. – Son 3. Son 4. Secretary of State for Health, Department of Health 5. Chief Executive, NHS England 6. CCG 7. , Chief Executive, CQC, 8. , Head of Quality and Nursing CCG I have also sent it to:- 1. - GP (for his information). 2. Ms Penelope Schofield, West Sussex Senior Coroner as Princess Royal Hospital is in her jurisdiction. Who may find it useful or of interest. 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: 9th April, 2021** **SIGNED BY:** V Hamilton-Deeley **Senior Coroner Brighton and Hove**