



Trust Headquarters
Nexus House
4 Gatwick Road
Crawley
West Sussex
RH10 9BG

Tel: 0300 123 0999
www.secamb.nhs.uk

8th June 2026
Internal Reference: 260510
Email:

Dear ,

Thank you for your request for information, which we received on **09/05/2025**.
We have considered your request under the Freedom of Information Act 2000.
Please ensure you quote the Internal Reference number above in any future correspondence.

Your Request

You have informed me via the trust response to FOI request internal reference 260501, made on this website, that the trust holds no central data on the deaths that have been referred to coroners. The trust has advised me: "The Trust does not maintain a central record of patient deaths reported to H M Coroner. Such reports are on individual patient inquest files rather than in a central record. It is not possible to collate or count them."

Please disclose if the trust has any mechanism(s) for assuring itself and third parties that it is correctly referring deaths to coroners. If so, please give details.

Has the trust, or any other party, since 2015 conducted any review or audit of the trust's processes to assess whether it is appropriately referring all relevant deaths to coroners in a timely manner and that it is disclosing all necessary information and documents to the coroner to comply with i) coronial law ii) with the statutory duty of candour (CQC regulation 20) iii) trust policy and procedure?

If any reviews and audits have been conducted, please share the relevant reports from these reviews and audits.



Formal Response

The Trust does have both processes and assurance mechanisms in place to support and oversee appropriate referral of deaths to the HM Coroner.

All patient safety incidents, including deaths, are recorded on the Trust's electronic incident reporting system (Datix). Patient deaths are reviewed weekly through Patient Safety Incident Review Group (IRG) meetings. These are led by area clinical leads and area quality leads. Each area panel reviews incidents that have occurred or come to light since the previous meeting as a result of an incident being recorded on Datix, a complaint being received, or a notification being received from Legal Services. The IRG panel decides whether a learning response is needed (and if so, what type), whether a referral to the HM Coroner is required, and whether Duty of Candour or an open and honest conversation should take place. If a Coroner referral is needed, the Patient Safety Team provides details of the case to the Legal Services Team, who in turn notify the HM Coroner.

The Trust can confirm that reviews of patient safety and incident management processes have been undertaken, with the most recent major review conducted in 2025 and a further internal review in 2026. These reviews considered the effectiveness of incident management processes, including escalation and referral pathways, including those relating to HM Coroner. In addition, there is regular informal liaison between Legal Services and the Area Quality Leads to ensure that this process and others are working as they should.

The Trust does not hold recorded information confirming that it has undertaken, or that any external organisation has undertaken on its behalf, a single, comprehensive review or audit since 2015 with the explicit purpose of assessing whether:

- all relevant deaths are consistently referred to the coroner in a timely manner; and
- all necessary information and documentation are disclosed to the coroner

Accordingly, the Trust does not hold any reports that directly meet the full scope of this request.

However, the Trust does undertake a range of ongoing assurance activities relevant to these matters. These include, but are not limited to, incident reporting and investigation processes (via Datix), oversight through management groups and governance review mechanisms. These arrangements provide scrutiny of individual cases, including those involving patient deaths, and support compliance with statutory and regulatory requirements.

These assurance processes are operational and case-based in nature and are not collated into a single overarching review or audit report of the type described in the request. As such, no specific documents are held that fall directly within scope.

Next steps

Some information held by the Trust is routinely published on our [website](#) and may be of assistance.

If you are dissatisfied with the Trust's response to your request, you have the right to ask for an internal review.

Requests for an internal review should be submitted within **40 working days** of the date of this response and should be sent to:

Richard Banks, Head of Corporate Governance at FOI@secamb.nhs.uk

The internal review will be conducted by an individual who was not directly involved in handling your original request, ordinarily the Trust's Data Protection Officer. We aim to complete internal reviews within **20 working days** of receipt.

If you remain dissatisfied following the outcome of the internal review, you may complain to the Information Commissioner's Office (ICO). The ICO generally expects complaints to be raised promptly following the completion of an internal review.

The easiest way to raise a complaint is via the ICO's website:
www.ico.org.uk/foicomplaints

Alternatively, you may write to:
Information Commissioner's Office
Wycliffe House
Water Lane
Wilmslow
SK9 5AF

Yours sincerely,

Corporate Governance Team

South East Coast Ambulance Service NHS Foundation Trust



Saving Lives,
Serving Our Communities

Chair: Michael Whitehouse CEO: Simon Weldon