Regulation 28: REPORT TO PREVENT FUTURE DEATHS

NOTE: This form is to be used **after** an inquest.

	REGULATION 28 REPORT TO PREVENT DEATHS **THIS REPORT IS BEING SENT TO:** **1 NHS England & NHS Improvement** **2 Department of Health and Social Care** **3 University Sussex NHS Foundation Trust**
1	**CORONER** I am Joanne ANDREWS, Area Coroner for the coroner area of West Sussex, Brighton and 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 21 December 2022 I commenced an investigation into the death of Tamara DAVIS aged 31. The investigation concluded at the end of the inquest on 14 October 2024. The conclusion of the inquest was that Ms Davis died from natural causes. As to the statutory questions in section 5 of the Coroners and Justice Act 2009 I recorded: Tamara Davis died on 13 December 2022 at the Royal Sussex County Hospital, Eastern Road, Brighton from multi organ failure which developed due to bronchopneumonia caused by Influenza A infection. She had been admitted to hospital on 10 December 2022 having been unwell for 5 days and was treated but sadly rapidly deteriorated due to the infection and could not recover.
4	**CIRCUMSTANCES OF THE DEATH** Tamara Davis had attended the Royal Sussex County Hospital on 10 December 2022 having been unwell for 5 days. She was assessed in Resus within the Emergency Department when her NEWS score was 8. She was treated for a suspected chest infection with IV antibiotics, fluids and paracetamol in the early hours of 11 December. Her clinical condition then appeared to be improving. She was moved into the Emergency Department corridor at 05:30 on 11 December as this was in use for patients. She then waited to be admitted to a ward for further treatment and

	observation. She remained in the ED corridor until 15:20 on 11 December. Tamara then moved to a cubicle in Majors within the Emergency Department and thereafter she experienced a significant deterioration in her condition which was treated and resulted in her admission to Intensive Care Unit. Despite treatment with supportive therapy she died on 13 December 2022. I did not find that the period in which Ms Davis was in the Emergency Department corridor caused or contributed to her death.
5	**CORONER'S CONCERNS** During the course of the investigation my inquiries revealed matters 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: During the inquest I heard evidence from clinicians at University Hospitals Sussex NHS Foundation Trust that when the Emergency Department of the Royal Sussex County Hospital, Brighton reached capacity patients would be moved to and treated in the corridor as there was no clinical area available to do so. The area is not designated as a clinical area and is not included within the Nursing staffing template for the ED. When Ms Davis was treated in the Royal Sussex County Hospital, Brighton on 11 December 2022 there were, at times, more than 20 patients in that area. Clinicians from University Hospitals Sussex NHS Foundation Trust gave evidence as to the action that is being taken by the Trust currently to (1) reduce the number of patients who present to the Emergency Department who could be seen by other services in the community and (2) to create an improved patient flow through the Royal Sussex County Hospital. The evidence was however that, despite these actions, the corridor remains in use for patients currently as there is insufficient space within the department to care for patients. There was no evidence as to when, and if, this practice would no longer be necessary. I heard that the provision of care in the ED corridor meant that patients lacked privacy, toilet facilities and confidentiality. I understood from the evidence of the clinicians that they were concerned that patients were being moved into the Corridor but there appeared to be no other option when the Emergency Department exceeds capacity. I heard that in the event of a major incident University Hospitals Sussex NHS Foundation Trust would have to clear the Emergency Department, as they had done on occasion, as this would be the only way to create the necessary clinical space when the department was already over capacity and using the corridor. I was also advised that the use of corridors to care for patients is not only an issue at the Royal Sussex County Hospital, Brighton but is used throughout the country when the capacities of Emergency Departments has been reached and there is nowhere to

	move patients to.
6	**ACTION SHOULD BE TAKEN** In my opinion action should be taken to prevent future deaths and I believe you (and/or 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 10 December 2024. I, the 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.
8	**COPIES and PUBLICATION** I have sent a copy of my report to the Chief Coroner and to the following Interested Persons **Family of Ms Davis** **University Hospitals Sussex NHS Foundation Trust** I am also under a duty to send a copy of your response to the Chief Coroner and all interested persons who in my opinion should receive it. I may also send a copy of your response to any person who I believe may find it useful or of interest. The Chief Coroner may publish either or both in a complete or redacted or summary form. She 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	Dated: 15/10/2024 J. Andrews Joanne ANDREWS Area Coroner for West Sussex, Brighton and Hove