Coroner Service
West Sussex, Brighton & Hove

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 University Hospitals Sussex NHS Foundation Trust** **2 NHS England & NHS Improvement** **3 Department of Health and Social Care**
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** I opened an investigation into the death of Maureen Brenda Batchelor on 26 February 2025 and this concluded with an inquest on 30 July 2025 which recorded: Maureen Brenda Batchelor died on 26 February 2025 at the Royal Sussex County Hospital, Eastern Road, Brighton from septicaemia which was caused by an aspiration pneumonia. The aspiration occurred when she vomited at home prior to her admission and then during a further episode whilst in hospital on 26 February 2025 caused by gastroenteritis and ileus.
4	**CIRCUMSTANCES OF THE DEATH** Mrs Batchelor was admitted to the Royal Sussex County Hospital in Brighton on 25 February 2025 having had a 5-day history of diarrhoea and vomiting. She was diagnosed with gastroenteritis and an aspiration pneumonia for which she was treated. She was placed into the corridor in the Emergency Department on her admission at 1042hrs and remained in the corridor until she became unwell at 0315hrs on 26 February 2025 with significant vomiting. Suction was not available in the corridor, so she had to be moved into the Resuscitation area to receive that treatment and to have a nasogastric tube placed. There was no evidence from which I could conclude that the period of time taken to transfer Mrs Batchelor from the corridor to the Resuscitation area more than minimally contributed to Mrs Batchelor's death.

	The evidence was that the corridor continues to be used to treat patients when there is insufficient capacity within the Emergency Department. Whilst the use of the corridor, a non-clinical area, had reduced there are still ongoing periods in which the corridor is in use.
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. I understand that at the time of Mrs Batchelor's attendance on 25 February there were 25 patients in the Emergency Department corridor, and this increased to 32 patients. 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. When asked there was no evidence as to when this practice would no longer be necessary. 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 treat patients and the only other alternative would be to hold patients in ambulances outside of the hospital. A Prevention of Future Deaths report in relation to the use of the corridor for patient care was made during an investigation into a death which occurred in December 2022 and the use of the corridor remains ongoing.
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 October 1 2025. 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 **The family of Mrs Batchelor** **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. They may send a copy of this report to any person who they believe 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: 05/08/2025 J. Andrews Joanne ANDREWS Area Coroner for West Sussex, Brighton and Hove