NHS
Lewisham and Greenwich
NHS Trust

University Hospital Lewisham
Lewisham High Street
London
SE13 6LH
[redacted]

HM Assistant Coroner J. Goldring
London Inner South Coroners Court
1 Tennis Street
Southwark
London
SE1 1 YD

1 June 2026

Dear Ms. Jenny Goldring

RESPONSE TO PREVENTION OF FUTURE DEATH REPORT
Mark Robert Smith

We are writing in response to your prevention of future death report dated 7 April 2026, concerning the care provided to Mr. Mark Robert Smith. The Trust continue to extend our condolences to the family of Mr. Smith.

- The Coroner will note that seven years have passed since Mr Smith's death and the context of discharges has changed dramatically across the NHS, in particular since the Covid-19 pandemic. This was raised as part of the evidence provided to the Coroner in the context of the inquest.
- We refer the Coroner to the two witness statements that were provided in the course of the inquest dealing with the changes made since Mr Smith's death. These witness statements were comprehensive and dealt with the concerns raised within the Prevention of Future Deaths report (before it was issued) and we will not repeat the entirety of their content within this response.
- It is regretful that no opportunity was provided for the author of two witness statements concerning changes made since Mr Smith's death to provide oral evidence at the inquest hearing. This would have allowed for the Coroner and Mr Smith's family to ask questions of that witness and to understand in greater detail the changes that have been made at the Trust.
- The issues in this case related to the practice of individuals. There is a limit to what the Trust can do insofar as individual clinical decision-making is concerned.

The Trust considers it had taken steps to mitigate the concerns the Coroner raises insofar as possible. This was made clear within the evidence and representations made to the Coroner in the course of the inquest.

However, regarding the coroner's report which highlighted two matters of concern i.e. *"I remain concerned a similar situation could arise as did in Mark's case regarding a discharge back to prison from QEH without an MDT meeting despite repeated requests from prison healthcare and there could be a risk to life. I note PFD evidence provided regarding improved liaison between QEH and the prison GP but note no reference to liaison between QEH and the head of the healthcare in prison, who visited QEH twice in Mark's case. Further, as recently as 2025 an incident occurred when there was a lack of understanding at QEH around the limited provision in healthcare in prison. I am concerned as to how awareness of the limits of prison healthcare will be disseminated on a continuing basis to new and locum staff at QEH*". **(QEH and Practice Plus Group)**

We provide further information as to these concerns below.

a. <u>Consultant oversight on discharges</u>

All discharges are overseen by a consultant. It is a critical part of hospital discharge processes to ensure patients are medically stable and follow up care is arranged and an expectation of best practice as per Royal College of Physicians guidelines. This is taught through supervised clinical practice on wards, mentoring and in formal teaching. There are also hospital and local departmental induction programmes in the Trust which now include a more formal structure on these processes. Consultants have also been reminded of the processes to provide consistent mentorship and guidance for their residents and teams.

The Acute physician consultants conduct a second ward/board round in the afternoon to review results and discharge plans with the team in a multidisciplinary manner as per Acute Medicine guidance recommendations outlined in the RCP Acute Care Toolkit 4 and the Society for Acute Medicine's Six to Help Fix guidelines. These guidelines ensure that patients are safe and meet the standards of acute care.

b. <u>MDT decision for discharge</u>

We have established daily morning MDT board rounds on all wards whereby all therapies are represented. If a psychiatric assessment is required before discharge, any member of the MDT team would alert the medical team to ensure that this is in place before discharge. The MDT team includes medics, nurses, physiotherapy and occupational therapists as well as the discharging team and operational teams.

Whilst board rounds were in place in 2019 when Mr Smith died, since 2025 we have had a Trust Board Round Improvements working group. This group works across Lewisham and Greenwich NHS Trust to improve patient flow, discharge planning and multidisciplinary collaboration. Board Round Operating Standards were developed through extensive engagement with nursing, therapy, operational and clinical teams and these were embedded through a phased Board Round coaching programme across all medical and surgical wards. The structure is underpinned by the

S.H.O.P framework (Sick, Home, Other patients, Plan) which is widely adopted across NHS Trusts and supported by national guidance from NHS England and the Getting it Right First Time (GIRFT) programme. It brings structure, consistency and a patient-centred focus to board rounds, ensuring teams priories clinical risk, discharge readiness and operational clarity.

c. <u>Communication between hospital and prison healthcare teams</u>

We promote regular discussions between specialist medical teams and prison healthcare. We work with the lead GPs within prisons through phone conversations as well as via email correspondence about individual patients. This includes discussions around post-discharge management and ongoing medication planning (e.g. intravenous antibiotics being delivered in the prison healthcare services). The medical team at the hospital correspond with the two lead GPs at the prisons within our area who are (a) [redacted], lead GP at HMP Thameside and Regional Medical Lead for London Prisons and (b) [redacted] lead GP at HMP Belmarsh.

Additionally, prison GPs now have access to the on-call medical or surgical registrar at Queen Elizabeth Hospital who would then re-direct to the on-call consultant as required. The on-call consultant for the relevant specialty is also available through the hospital switchboard that holds the on-call rota.

This does not replace the expected process that if a patient anywhere in the community is unwell (to include prison) and there are immediate concerns, advanced or basic life support should be provided as appropriate, and the patient should be conveyed to Queen Elizabeth Hospital via ambulance.

To encourage further multi-disciplinary discussions between Queen Elizabeth Hospital and prison GPs we have reached out to the GP leads at the prison to develop a more integrated approach to patient care. [redacted] after discussions with the nursing and admin teams from prison have made suggestions for improvement including better communication between teams and improved clarity with written communication in particular discharge summaries. We are therefore planning to develop a working group to discuss care improvements between the hospital and prison healthcare.

The Trust has worked to improve discharge summary documentation. In June 2020 a Quality Improvement project was started to standardise the content of discharge summaries to improve the transfer of patient care from hospital to community. This work continues to be driven across the Trust to maintain and improve the quality of documentation. There are also ongoing teaching sessions being incorporated into the medical resident teaching reinforcing the importance of

clarity and accuracy in the discharge documentation.

We are working with a local GP principal to construct a model discharge summary approach. There is a current audit project to review and improve on work started in 2020. We are aiming to deliver face to face teaching and subsequently videoed work to incoming resident doctor at induction starting in August 2026.

d. Other

As a Trust, we ensure that learning from cases is regularly shared at local governance meetings as well as at formal divisional meetings. 'Sharing the Learning' events are conducted in the trust. Mark's case and the learning from it was discussed on an anonymous basis including reference to the issues raised at the inquest. At a divisional level, QEH Medicine holds a quarterly event, and this case was discussed and shared on the 29th April 2026. The case was also presented at the all-day Trust wide learning event on the 23rd April 2026.

On behalf of Lewisham and Greenwich NHS Trust, we hope that these explanations provide some assurance to the Coroner that our systems have been improved to mitigate against any similar issues arising in the future but also the work going forward to improve, in particular in relation to discharge planning and communication with local prisons.

Yours sincerely

[redacted]

[redacted]
Chief Medical Officer
Lewisham & Greenwich NHS Trust