REGULATION 29 RESPONSE TO A REPORT ON ACTION TO PREVENT FUTURE DEATHS

Please do not include any living person names in this document, in accordance with the Chief Coroner's publication policy PDF.

THIS RESPONSE IS BEING SENT TO:

The Area Coroner, Joanne Andrews for the Coroner Area West Sussex, Brighton and Hove in response to a '**REPORT TO PREVENT FUTURE DEATH REGULATION 28**' following an investigation into the death of **David John SMART**, and an inquest that concluded on **19 May 2026**.

1.	**RESPONDENT** In line with our duty under Regulation 29 of the Coroners (Investigations) Regulations 2013, **University Hospitals Sussex NHS Foundation Trust** provides this response within 56 days of the date of the Report to Prevent Future Deaths or any extension granted.
2.	**DATE OF RESPONSE** 19 June 2026
3.	**CONFIRMATION OF CORONER'S MATTERS OF CONCERN** The **MATTERS OF CONCERN** were identified in the report are as follows: During the inquest I heard evidence that at the of Mr Smart's attendance to the Emergency Department of the Royal Sussex County Hospital, Brighton that there were around 20 patients in the corridor as the Department had reached capacity and there was no clinical area available to do so. I understand from previous inquests that the area is not designated as a clinical area. I have heard in other inquests relating to deaths prior to June 2025 that is being taken by University Hospitals Sussex NHS Foundation 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 in this inquest was that, despite these actions, the corridor continues to be used when the Emergency Department reaches capacity. 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. Prevention of Future Death reports in relation to the use of the corridor for patient care was made during investigations into deaths which occurred in

	December 2022 and February 2025 and the use of the corridor remains ongoing.
4.	**DETAILS OF ACTION TAKEN,** how has the concern been addressed. The use of Emergency Department (ED) corridors to care for patients is a significant national problem. The Executive team is working closely with very senior members of the local ICB (Integrated Care Board), CQC (Care Quality Commission), local mental health Trust, and social care providers to tackle the problem. As a Trust we cannot solve the problem without all partner organisations working together. I am so sorry you have had the need to write to us again with your concerns and I too share these concerns. The Medicine Divisional Leadership team, the Hospital Directors, and the Executive team are continuously working on several separate but linked workstreams aiming to eradicate the use of the ED corridor. This is vital for patient care to ensure that our patients are treated in the most appropriate clinical environment, with dignity, and without delays. The key workstreams include strengthening the 'Direct to Specialty Pathways between the Emergency Department and the Trust's specialties for patients who are accepted for care directly by the relevant specialty on presentation to the ED. We are continually looking to expand the acceptance criteria to ensure that we are maximising this process. Additionally, we are directing inter-hospital referrals away from the ED and transferring patients directly to the in-patient bed base. We have strengthened our Same Day Emergency Care (SDEC) medical model from a 7 day a week service to a 24/7 unit where patients can be streamed away from the ED and seen and treated on the Acute Medical Unit (AMU). These workstreams have all been overseen through the ED Quality Oversight Group. The Trust is currently exploring working with a company (NEWTON) to increase the opportunity for decompressing the EDs, further strengthening the SDECs across the Trust, and improving flow once patients do not have a criteria to reside. All specialties in-reach to the ED and we operate a 3/2/1 bleep system to ensure this is fast and effective. We continue to run 'Emergency Physician In Charge' (EPIC) huddles and Corridor huddles multiple times a day 24/7 days a week. These allow line-by-line reviews of every patient in the corridor to ensure all appropriate pathways are considered; this is known as check and challenge and provides live escalation. The Hospital Alternative Oversight Programme (HALO) is embedded in daily practice and continues to be reviewed regularly to ensure all opportunities are maximised. This work is aimed at the avoidance of inappropriate hospital admissions, to optimise patient flow through the hospital, and smooth discharge pathways and processes. This includes:

	• Unscheduled care Navigation Hub • Frailty Care Home Outreach & Red Bag Launch • Frailty High Weald Lewes & Havens Outreach • Integrated front door therapies team RSCH (Royal Sussex County Hospital) • Virtual Health, both General Virtual Ward and Respiratory Home Monitoring Services • Frailty and Respiratory SDEC (Same Day Emergency Care) Optimisation • Interprofessional Standards • UTC (Urgent Treatment Centre) Optimisation • Early Discharge Planning • Deconditioning Prevention • Tiered Acuity Model These initiatives are in collaboration with our colleagues from the ICB, Sussex Community NHS Foundation Trust (SCFT), South East Coast Ambulance Service (SECAmb), Sussex Partnership NHS Foundation Trust (SPFT), and Brighton & Hove City Council (BHCC). There continues to be ongoing collaborative work with the local Mental Health Trust, SPFT to ensure that patients requiring mental health hospital admission are admitted to an appropriate mental health unit as quickly as possible or avoid ED attendance in the first place. We continue to use ambulatory space as effectively as possible across the ED to maximise clinical space and reduce overcrowding. The Continuous Flow Model is embedded within the Medicine Division and continues to ensure earlier movement of patients from the Acute Floor and reducing the time patients are waiting in the ED for admission to a ward. There are ongoing discussions with clinical Divisions outside the Medicine Division to implement a similar model. We recognise that the contributory factors leading to corridor care are multi-faceted and complex. As these issues involve a multi-agency approach, working alongside our system partners, we acknowledge that eradicating care in non-clinical environments will take considerable time. Therefore, alongside these actions, the ED team is continuing to implement local measures to improve the quality and safety for patients receiving care in these areas. Examples of these are: • Digitisation, including electronic observations and prescribing • Intentional Rounding • Fundamental Standards of Care and Corridor standard work • Weekly review of high risks • Repurposing clinical space to facilitate dedicated space for monitoring patients who have been stepped down from the Resuscitation area of ED. Our Acute Floor Reconfiguration, which is a £48 million capital improvement programme to improve patient and staff experience at the Royal Sussex County

	Hospital, is well underway. The first phase has now been completed with the opening of the new Acute Medical Unit and 24/7 Medical SDEC (same day emergency care). Phase 2 is scheduled to commence in early 2027.
5.	**DETAILS OF FURTHER ACTION PROPOSED** We all agree that corridor care must be stopped both locally and nationally. The Trust has made great progress with this and continues to work with the ICB and other organisations for their assistance to make sure flow in and out of ED is possible so when patients who do not require acute hospital care for a physical health condition, they are in appropriate mental health and social care environments outside of the acute Trust.
6.	**SIGNATURE**  Chief Executive University Hospitals Sussex NHS Foundation Trust