

**REPORT TO PREVENT FUTURE DEATHS
REGULATION 28 OF THE CORONERS (INVESTIGATIONS) REGULATIONS
2013**

Please do not include any living persons' names in this document, in accordance with the Chief Coroner's [PFD Publication Policy \(2026\)](#).

1. CORONER

I am Joanne ANDREWS, Area Coroner, for the coroner area of West Sussex, Brighton and Hove.

2. DATE OF REPORT

22 May 2026

3. 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.

4. 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

You are under a duty to respond to this report within 56 days of the date of this report, namely by July 17, 2026. I, the coroner, may extend the period if an appropriate application is made.

5. YOUR RESPONSE

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.

I have a duty to send a copy of your response to the Chief Coroner.

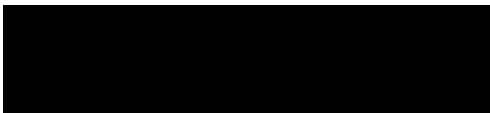
In accordance with the Chief Coroner's Publication Policy, you should send me any representations regarding publication of your response. These representations should be made at the same time as the response is provided. I will pass any representations received to the Chief Coroner for a decision.

Please note any links to webpages included in the response will not be checked for sensitive information prior to publication, as the information is already online.

The names of those who do not respond to PFD reports are regularly published on the Chief Coroner's webpages [Non-responses to Prevention of Future Death \(PFD\) reports - Courts and Tribunals Judiciary](#).

6.	SUMMARY OF CORONER'S CONCERN 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.
7.	ACTION SHOULD BE TAKEN In my opinion unless action is taken to address the above concerns then there is a significant risk of future deaths and I believe each of you have the power to take such action.
8.	INVESTIGATION AND INQUEST On 18 June 2025 I commenced an investigation into the death of David John Smart aged 79. The investigation concluded at the end of the inquest on 19 May 2026. The conclusion of the inquest was that David John Smart died on 14 June 2025 at the Royal Sussex County Hospital, Eastern Road, Brighton from known complications of a treatment to reverse his Rivaroxaban. He needed the reversal in order to receive surgical treatment for a life-threatening rectal bleed which developed on 13 June 2025 following a polypectomy procedure on 5 June 2025.
9.	CIRCUMSTANCES OF DEATH

	On 5 June 2025, David John Smart underwent a polypectomy. He was on Rivaroxaban for atrial fibrillation which was stopped prior to the procedure due to the risk of increased bleeding. He underwent the procedure without any immediate complications and was discharged with instructions to resume his Rivaroxaban after 72 hours which he did. On Friday 13 June 2025 he developed a significant rectal bleed and was advised by the Endoscopy Unit to attend the Emergency Department at the Royal Sussex County Hospital, Brighton which he did that afternoon. He was assessed in the Emergency Department and a decision was made to attempt conservative management of the bleed but he continued to experience bleeding and a decision was made the next morning that he would undergo surgical intervention to attempt to resolve the same. He was then discussed with the Haematologists as to the implications of the Rivaroxaban and authorised to have the only reversal agent available. There were no complications with the surgery which sealed the bleeding vessels around the site of his polypectomy. The reversal treatment of Andexanet Alfa is known to have recognised complications of thrombosis which Mr Smart sadly suffered after its administration. He sadly died from the complications resulting from the use of the Andexanet Alfa treatment on 14 June 2025.
10.	CORONER'S CONCERNS During the course of the inquest I heard evidence 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 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.
11.	COPIES AND PUBLICATION OF THIS REPORT I have a duty to send a copy of my report to every Interested Person who in my opinion should receive it. I also may send a copy of the report to any other person who I believe may find it useful or of interest. I can confirm I have sent the report to: The family of Mr Smart I also have a duty to send a copy of the report to the Chief Coroner. You may make representations to me, the coroner, about the publication of the contents of this report in line with Chief Coroner's PFD Publication Policy (2026). Any representations will be sent to the Chief Coroner alongside the report. Please refer to box 4 above for additional information relating to the publication of reports and responses.
12.	SIGNATURE  Joanne ANDREWS Area Coroner for West Sussex, Brighton and Hove