	REGULATION 28 REPORT TO PREVENT **FUTURE DEATHSTHIS REPORT IS BEING SENT** **TO:** **1. [redacted], Group Chief Executive, St George's. Epsom and St Helier Hospital Group.** **2. [redacted], Chief Executive Officer of NHS England.**
1	**CORONER** I am Caroline Topping assistant coroner, for the coroner area of Surrey.
2	**CORONER'S LEGAL POWERS** I make this report under paragraph 7, Schedule 5, of the Coroners and Justice Act 2009and Regulations 28 and 29 of the Coroners (Investigations) Regulations 2013.
3	**INVESTIGATION and INQUEST** An inquest into the death of Mr Timothy Charles Clayton was opened on the 29th December 2022 and resumed on the 16th January 2024. The inquest was concluded on the 12th March 2024 when evidence in respect of matters pertaining to this report was heard. It was concluded that Mr Clayton died on the 12th December 2022 at Epsom General Hospital and the medical cause of his death was: 1a Hypothermia 1b Self Neglect and Chronic Alcohol Excess A narrative conclusion found that: Timothy Clayton was suffering from alcohol related brain damage and malnutrition as result of chronic alcohol use. His mobility was impacted and he had fluctuating confusion. He was found hypothermic at home on the 27th October 2022, taken to hospital and discharged. On the 20th November 2022 he was again hypothermic and was admitted to hospital. He was discharged on the 24th November 2022 to be cared for by a family member. On the 29th November 2022 he was admitted to hospital and transferred to Epsom General Hospital suffering with reduced mobility, slurred speech and confusion. The underlying cause of his condition was not diagnosed. He was found to be medically fit for discharge. The discharge planning was not undertaken in accordance with the hospital policy. No heed was paid to his family's concerns that he was not well enough to care for himself. He was discharged on the 5th December 2022 to live at his own flat. The heating was inadequate and he self neglected in relation to eating. He was found profoundly hypothermic on the 11th

	December 2022 and admitted to Epsom General Hospital. He died from the effects of hypothermia on the 12th December 2022. Pressure on staff to vacate hospital bed spaces led to inadequate discharge planning and more than minimally contributed to the death.
4	**CIRCUMSTANCES OF THE DEATH** Mr Clayton's health had declined in the summer of 2022 and he had lost a significant amount of weight. He was suffering from alcohol related brain damage and continued to abuse alcohol. His mobility was impacted and he had fluctuating confusion. He was self neglecting and his ability to live alone was reduced. He developed hypothermia in an inadequately heated flat. There was a lack of information sharing and investigation in relation to the discharge planning for Mr Clayton. Contrary to the Trust's policy he was not identified as a vulnerable patient. His family was not involved in the discharge planning. On a number of occasions, they raised their concerns as to his ability to live independently and were ignored. Staff were unaware of the discharge planning policy. The underlying cause for his presentation was not diagnosed. Discharge decisions were taken in a vacuum without understanding the recent history of frequent admissions, his diagnosis and without sufficient investigation of his home circumstances. An assumption that Mr Clayton had capacity was made and used to justify his discharge without considering whether he could make informed decisions about his ability to live alone without knowing what underlay his deterioration and how his ability to self-care was impacted. It was accepted that pressure to vacate hospital bed spaces played a part in the inadequacy of discharge planning. The imperative to free up a bed space led to a rushed discharge on the 5th December 2022 without an adequate care plan being in place.
5	**CORONER'S CONCERNS** During the course of the inquest the evidence 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: The Trust has considered the issues raised in this case and put in place a number of improvements in relation to effective information sharing and recognition of safeguarding issues, including self-neglect. I remain concerned that: In relation to Epsom General Hospital: 1. The policy in relation to discharge planning remains under review, including how families are to be involved, so it has not been possible to assess the adequacy of the new policy.

	2. There was a misunderstanding by a clinician in relation to whether capacity to make a decision can be relied on to justify actions taken when the requisite information which needed to be considered by Mr Clayton in relation to that decision and its consequences had not been provided to him. Mr Clayton's expressed wish to go home alone, without any care plan in place, was relied on, erroneously, to justify an unsafe discharge on the basis that he had capacity. In relation to both Epsom General Hospital and NHS England 3. The pressure to vacate bed spaces impacted on clinicians' ability to prepare a properly considered discharge plan and led to rushed underinformed decision making.
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 the 12th June 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: Mr Clayton's family Epsom General Hospital Surrey County Council The Care Quality Commission 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 other person who I believe may find ituseful or of interest. The Chief Coroner may publish either or both in a complete or redacted or summary form. He may send a copy of this report to any person who he believes may find it usefulor of interest.

	You may make representations to me, the coroner, at the time of your response, aboutthe release or the publication of your response.
9	**Caroline Topping, 17th April 2024**