REGULATION 28: REPORT TO PREVENT FUTURE DEATHS

	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO:** **Secretary of State of The Department of Health and Social Care**
1	**CORONER** I am Alison Mutch , senior coroner, for the coroner area of Manchester South
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** On 11th September 2024 I commenced an investigation into the death of Kenneth James CLAYTON. The investigation concluded at the end of the inquest on 27th January 2025. The conclusion of the inquest was NARRATIVE: **Died from the complications of an unobserved fall that occurred in the Emergency Department during a prolonged wait for an inpatient bed. The medical cause of death was 1a) Bronchopneumonia 1b) Neck of Femur Fracture (operated on) 1c) Fall II) Frailty, Vascular Dementia, Acute Kidney Injury.**
4	**CIRCUMSTANCES OF THE DEATH** Kenneth James Clayton was taken to Tameside General Hospital after two falls at his home address. He was assessed as requiring inpatient admission to a medical ward. Whilst waiting for an inpatient bed to become available he had an unobserved fall in the Emergency Department. He was found to have fractured his neck of femur and was operated on. Post operatively he deteriorated and developed complications from the fracture and operation. He died at Tameside General Hospital on 23rd August 2024.
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. – 1. The inquest heard evidence that a key factor in the fall was the prolonged time Mr Clayton was in the Emergency Department waiting for a bed to become available on a ward. The evidence was that he had been in the emergency department for about 8 hours when he fell. The inquest was told that the design of an Emergency Department is not suited to a need for prolonged observation of high falls risk patients. In addition generally patients are cared for on hospital trolleys which cannot be lowered in the way a hospital bed can be which further increases the risk of falls. 2. Prolonged waits in Emergency Department were on the evidence given to the inquest not unusual. As an example the court was told that on the morning the

	inquest was heard there were patients who had been waiting 40 hours for a bed on a ward. 3. The inquest was told that the primary reason for the challenges in moving patients through the Emergency Department was availability of beds. The evidence given was that the main challenge in freeing up beds was delayed discharge of patients who were medically ready for discharge but who needed a care package or a care home place to facilitate a safe discharge. 4. The inquest was told that for patient safety it was important, that whilst there were delays in ED throughput of patients, that a robust falls risk management system was in place. Tameside Hospital had put additional measures in place to manage falls risk in ED in a more consistent way but it was unclear what steps were in place nationally to manage falls risk in a consistent way in Emergency Departments.
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 16th April 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 son of Mr Clayton on behalf of the family, Tameside General Hospital who may find it useful or of interest. I am also under a duty to send the Chief Coroner a copy of your response. 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	**Alison Mutch** **HM Senior Coroner**  **19/02/2025**