REGULATION 28: REPORT TO PREVENT FUTURE DEATHS

	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS THIS REPORT IS BEING SENT TO: The Secretary of State for Health; Greater Manchester Health and Social Care Partnership
1	CORONER I am Alison Mutch, Senior Coroner, for the Coroner Area of Greater 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 25th January 2020 I commenced an investigation into the death of John Cheetham. The investigation concluded on the 26th June 2020 and the conclusion was one of **Narrative: Died from the complications of an unwitnessed fall whilst unobserved during a prolonged wait in the Emergency Department for a hospital bed.** The medical cause of death was **1a) Cerebral oedema; 1b) Intracranial haemorrhage (right parietal haematoma); 1c) Fall; II) Clostridium difficile infection, cervical odontoid fracture, metallic aortic valve replacement, rib fractures**
4	CIRCUMSTANCES OF THE DEATH John Cheetham had an accidental fall at his home address and was admitted to Stepping Hill Hospital on 22nd December at 08:11. A CT scan identified he had fractured his odontoid peg and ribs. A decision was made to admit him to hospital. He was a high falls risk. A medical bed was not available due to bed capacity. At 02:00 he remained in the Emergency Department, 18 hours after his arrival awaiting a bed. Whilst unobserved he fell. A CT scan identified he had sustained a subarachnoid haemorrhage from the fall. He was moved to a medical ward at 16:40 on 23rd December from the Emergency Department. A repeat CT scan on 23rd December showed the bleed was increasing. His GCS was 9. His anticoagulation had been reversed and his INR was 1.2. On 31st December his infection markers were raised and on 1st January antibiotics were given for a chest infection. His NEWS improved and on 8th January antibiotics were stopped. On 18th January 2020 he deteriorated with a GCS of 3 and NEWS of 7. A CT

	scan showed significant cerebral oedema. He had also developed Clostridium Difficile. Treatment was given including anti-seizure medication and antibiotics. He continued to deteriorate and died on 19th January 2020 at Stepping Hill Hospital.
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 will 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 that since the events leading up to Mr Cheetham's death the Trust has taken steps to reduce the risk of falls in the Emergency Department. The inquest heard evidence that a number of the issues that led to his death are part of a wider national issue. 2. The evidence given to the inquest was that the Trust and all other acute hospitals in Greater Manchester were at that time facing significant challenges in terms of ED capacity. The capacity issues on that day were not one off but had been on going throughout December and continued through the winter months. As a result the ED was regularly overcrowded and elderly, vulnerable patients were regularly waiting for very long periods of time in unsuitable conditions in the ED. 3. The prolonged wait Mr Cheetham had was a result of lack of bed capacity. The inquest was told that this was due to delayed discharges of elderly in-patients back into the community because of challenges faced by adult social care. On the day that Mr Cheetham was waiting for a bed there were over 20 other patients in a similar position waiting for an in-patient bed. 4. The inquest was also told that a shortage of nurses nationally trained to work in ED had meant that the unit was short staffed on the night he fell and suffered a catastrophic injury. 5. In his case a risk assessment was not carried out at the earliest opportunity. The inquest heard that when an ED is facing the demands caused by capacity issues risk assessments are not always prioritised increasing the risks faced by elderly patients at risk of falls.

6	ACTION SHOULD BE TAKEN In my opinion action should be taken to prevent future deaths and I believe you 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 7th September 2020. 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, namely Mrs [redacted] wife of the deceased, 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. He may send a copy of this report to any person who he believes 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 OBE** **HM Senior Coroner** **13.07.2020**