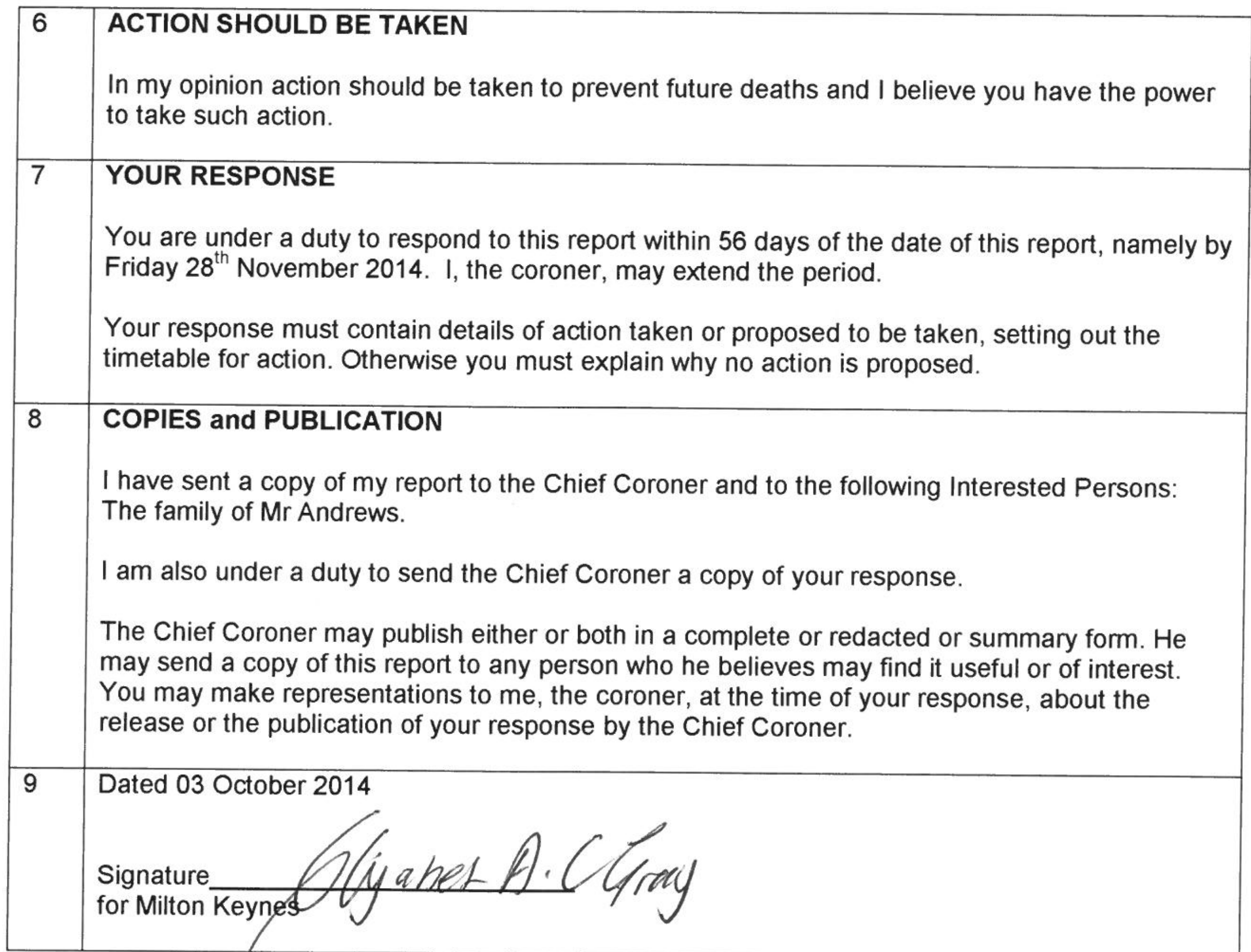
ELIZABETH ANNE CLARE GRAY ASSISTANT CORONE

for Milton Keynes

	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO: Chief Executive Milton Keynes Hospital**
1	**CORONER** I am Elizabeth Anne Clare Gray, Assistant Coroner for Milton Keynes.
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. http://www.legislation.gov.uk/ukpga/2009/25/schedule/5/paragraph/7 http://www.legislation.gov.uk/uksi/2013/1629/part/7/made
3	**INVESTIGATION and INQUEST** On 02/06/2014 I commenced an investigation into the death of John Andrews, 76 . The investigation concluded at the end of the inquest on 26 September 2014. The conclusion of the inquest was Accident Fell at home on 31st March and again on 25th April. Hospital admission followed and subdural haematoma diagnosed leading to pneumonia and death on 1st June 2014. Pneumonia Sub-Dural Haemorrhage Recurrent Falls Stroke Previous Myocardial Infarction
4	**CIRCUMSTANCES OF THE DEATH** PMH: Stroke, occipital lobe & MCA infarct which has affected his visual field resulting in recurrent falls at home. Previous MI, CABG in 1992.31/03/14 MKH MKH due to chronic subdural secondary to a fall, discharged from stroke unit 25/04/14 to home. At home fell again and readmitted to MKH during the early hours of the morning due to head injury. CT scan of brain shows small sub acute subdural haemorrhage (no significant changes from previous scan), chronic occipital infarct. CT of abdomen showed right internal iliac artery aneurysm. Pt sat in chair, tried to stand & fell again. Moved to stroke ward. Confused & agitated. 02/05/14 Fell again, no apparent injuries, 05/05/14 1 to 1 care so as to prevent him getting out of bed or chair. 13/05/14 Becoming chesty, signs of chest infection. 19/05/14 Change of medication due to past cardiac history, pt developed a twitch which was thought to be precursor to fits and so given medication to control it. Pt refusing diet, fluids limited. NG tube inserted, family informed of very poor prognosis, DNR signed, treatment continues, pt continues to decline, RIP.
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. – [BRIEF SUMMARY OF MATTERS OF CONCERN] (1) Mr Andrews was admitted to Milton Keynes Hospital on 31st March 2014 following a fall. (2) Following detailed discussion with [redacted] Mr Andrews was discharged from hospital. (3) Mr Andrews was insistent that he wanted to be discharged. (4) [redacted] agreed reluctantly, but decided that a discharge would be in Mr Andrews best interest given his insistence upon leaving and returning home, plus his unwillingness to remain in Milton Keynes Hospital. (5) Upon discharge the plan agreed with [redacted] was to implement a care package to assist

	Mr Andrews at home. (6) On the day of discharge Mr Andrews family were not advised of his discharge. As a result, Mr Andrews arrived home by ambulance alone, the heating was not on and there were no groceries. Importantly the family were not present to give any physical assistance. (7) Formal care arrangements were not arranged until 2-3 days later (Monday). It was too late, as Mr Andrews had fallen when home alone on the first day and was found on the floor by his son, who happened to phone his father, to be told he was at home. (8) Discharge arrangements for frail, vulnerable patients must ensure that patients can only be sent home if there is appropriate care in place at home to meet their needs.



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 Friday 28th November 2014. 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 family of Mr Andrews. 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	Dated 03 October 2014 Signature________________ for Milton Keynes