REGULATION 28: REPORT TO PREVENT FUTURE DEATHS .

	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO:** **1. Medical Director, UHSM, Wythenshawe Hospital.** **2. [redacted] Next of Kin.** **3. Chief Coroner** **4. Lord Chancellor**
1	**CORONER** I am Mrs Jean Harkin , Assistant Coroner, for the coroner area of City of Manchester.
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	**INQUEST Date:- 19th September 2016** **Name of Deceased:- John Graham SMITH** **Date of Birth:- 30th May 1938** **Date of Death:- 5th October 2015**
4	**CIRCUMSTANCES OF THE DEATH** Mr Smith had been admitted to Wythenshawe Hospital Manchester on 13th September 2015 following a fall in his garden. He looked after his wife who had dementia and he himself had been diagnosed with dementia. Despite concerns from paramedics (who made a safeguarding referral), his family and [redacted] (CPN), who advised an intermediate care assessment, he was discharged home. It was clear to all that Mr Smith had incontinence problems and had to walk upstairs to the bathroom. He was unsteady on his feet and the stairs at home were difficult to navigate. He also struggled to look after himself. He was discharged home on 22nd September 2015. Mr Smith was re-admitted to Wythenshawe Hospital on 24th September 2015 following a fall at his home address. He underwent surgery to repair a fractured neck of femur on 26th September 2015 and post surgery he developed aspiration pneumonia and died at 23.59 hours on 1st October 2015.

5	**CORONER'S CONCERNS** 1. Inadequate risk assessment prior to discharge – evidence heard in court confirmed that the assessment was done using 3 standard steps/stairs. There was no consideration of toilet needs requiring urgent toileting and Mr Smith having to climb a difficult staircase in a hurry. Further, there were professional and family concerns raised regarding discharge. 2. Inadequate questioning for assessment and discharge purpose - [redacted] Consultant Orthopaedic Surgeon, agreed in court that he would not have discharged Mr Smith knowing the above. As a result of the discharge of a mobility and incontinent comprised patient, also suffering with dementia and caring for his wife who also had dementia (in respite care prior to Mr Smith's discharge) Mr Smith suffered a further fall at home which lead to his death indirectly.
6	**ACTION SHOULD BE TAKEN** In my opinion action should be taken to prevent future deaths and I believe you and 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 **13 December 2016**. 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**
9	**[DATE]** **[SIGNED BY CORONER]** **18 October 2016**