Thomas Ralph Osborne
Senior Coroner for Milton Keynes

	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO: Joe Harrison, Chief Executive Milton Keynes University Hospital**
1	**CORONER** I am Thomas Ralph Osborne, Senior 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 22nd September 2016 I commenced an investigation into the death of Mr William Frederick Wilkes, aged 80. The investigation concluded at the end of the inquest on 10th May 2017. The conclusion of the inquest was that he died as the result of an accident.
4	**CIRCUMSTANCES OF THE DEATH** The deceased was admitted to Milton Keynes University Hospital on 4th July 2016 following a fall at Neath House Residential Home. By 19th July 2016 the deceased was ready for discharge from the hospital. Neath House indicated that they were unable to meet his needs unless a carer could be provided to stay with him 24 hours a day. A Continuing Healthcare Checklist was completed on 26th July 2016. The Decision Support Tool was completed and an assessment by a Continuing Healthcare Nurse Assessor was completed on 8th August 2016. The report and confirmation of funding was completed on 17 August 2016. The Continuing Healthcare Team was unable to find a suitable placement for the deceased. The file was misplaced in the non-eligible tray that added to the delay from 19th August 2016 to the 30th August 2016. The failure to discharge the deceased resulted in him being cared for on Ward 18 which was inappropriate to meet his needs. There was a failure in communication between the hospital, the CCG and the family. The deceased was placed on one-to-one enhanced care but it was not always provided. The deceased suffered a further fall on 18th September 2016 and fractured his hip. The deceased died on 22nd September 2016.

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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. – During the course of the inquest it became apparent that the protocol and procedure for discharge of someone from hospital was cumbersome and time-consuming. The result in this case was that, although the deceased was ready for discharge to a nursing home on the 19th July, he was not able to be transferred to a more appropriate care home prior to his death on 22nd September. I also heard from the patient discharge lead from the hospital that the system was in urgent need of review. 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. Concerns 1. That a system needs to be put in place locally so that the procedures for effecting discharge can be implemented within days rather than weeks. 2. That a local protocol should be considered by both the Hospital Trust and the Clinical Commissioning Group for Milton Keynes.

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 11th July 2017. 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 Wilkes • The Care Quality Commission 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 17th May 2017 Signature_____ Senior Coroner for Milton Keynes

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