ANNEX A

REGULATION 28: REPORT TO PREVENT FUTURE DEATHS (1)

*NOTE: This form is to be used **after** an inquest.*

	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO:** **1. Chief Executive of Medway NHS Foundation Trust** **2. Head of Adult Safeguarding Kent County Council**
1	**CORONER** I am Sonia Hayes assistant coroner for the coroner area of Mid Kent & Medway
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. [HYPERLINKS]
3	**INVESTIGATION and INQUEST** On 10 April 2019 an investigation was commenced into the death of CHRISTOPHER SMITH, 63. The investigation concluded at the end of the inquest on 31 July 2020. The conclusion of the inquest was a narrative conclusion. *'Christopher Smith died at Medway Maritime Hospital on 4th March 2019 of pneumonia with abscesses due to cellulitis with ulceration caused by peripheral vascular disease. He had two admissions to hospital in January and February and treated for sepsis and hyponatremia. He was discharged home alone on 10th February with intractable leg ulcers with no home assessment and no district nurse referral. This, and a lack of adequate nourishment caused an exacerbation of his leg ulcers that probably accelerated his death.'*
4	**CIRCUMSTANCES OF THE DEATH** Christopher Smith was admitted into hospital on 21st January 2019 with a history of peripheral vascular disease, extensive leg ulcers and epilepsy and was diagnosed with cellulitis and later with a chest infection. He was found not to have capacity for his treatment and a deprivation of liberty authorisation was sought. He remained on a discharge ward from 2nd February until 10th February during which time he suffered deterioration, nursing documentation was that he remained confused and his capacity for decisions around his care and treatment was not reassessed. Mr Smith was discharged without appropriate discharge planning or district nurse referral and his leg ulcers were not treated or dressed. Transport staff had significant concerns that his home was not safe or fit for habitation and raised a safeguarding alert when the hospital stated there was no bed for him. His family were not informed and found him five days later on the floor unable to move and with no dressings on his legs. He was readmitted to hospital on 15th February with sepsis, confusion and self-neglect and received treatment. There was a delay seeking the advice of a dietician and the advice was not followed. Mr Smith's assessed nutritional needs were not met. He continued to deteriorate and died on 4th March 2019.

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. – Evidence was heard that: (1) A recommended home assessment was not completed as part of Mr Smith's planned discharge from hospital. (2) The next of kin was incorrectly recorded on Mr Smith's medical records and the family were not informed of his discharge home as part of the discharge planning that he required care. (3) Mr Smith remained on a discharge ward from 2nd February until his discharge on 10th February even though he suffered a deterioration in his medical condition. Mr Smith's capacity fluctuated during his admission, he was noted by nurses to be confused and his capacity was not reassessed. (4) Nursing notes in respect of Mr Smith's discharge were incomplete, incorrect, and led to assumptions being made that Mr Smith a. had capacity to make decisions about his care and treatment b. was being cared for in the community. (5) Mr Smith has extensive leg ulcers that required specialist input. No district nurse referral was made to ensure that Mr Smith's leg ulcers were treated. (6) Transport staff returning Mr Smith home found he had no key. One was located and on entering the property found conditions that caused them serious concern about the hygiene and health and safety within the property with a leak, uncleanliness and exposed electrical wiring and that there was no bed. (7) Transport staff were informed by the hospital not to return Mr Smith to the hospital as there was no bed available and they therefore raised a safeguarding alert. The safeguarding alert was not acted upon and Mr Smith was found by family after five days lying on the floor of his home with no dressing on his legs, unable to move and with no access to food or drink. (8) On readmission to hospital his dietary requirements were not adequate for his needs.
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 31st March 2021. 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 [redacted](brother) and [redacted] (daughter). I am also under a duty to send a copy of your response to the Chief Coroner and all interested persons who in my opinion should receive it. I may also send a copy of your response to any other person who I believe may find it useful or of interest. 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.
9	**3rd February 2021** **Signature:** S. M. Hayes **Assistant Coroner Mid Kent & Medway**