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NHS
Milton Keynes
University Hospital
NHS Foundation Trust

Mr Tom Osborne
HM Senior Coroner
Milton Keynes Council
[redacted]

29 November 2022

Dear Mr Osborne

Regulation 28 Report following an Inquest into the death of Mr Ronald Kelly

I am writing following receipt of a Regulation 28 Report dated 15 November, following on from the Inquest you held on 10 November. I was saddened to hear of the death of Mr Kelly and the very sad circumstances around it which you describe as follows:

The deceased was found hanging [redacted] *… He had recently been discharged from hospital and was struggling to cope.*

I was surprised to receive a Regulation 28 report given that the Hospital was not represented at the Inquest, nor were we asked to provide statements in relation to the issues that caused you concern. The concern which you specifically raise for the hospital is as follows:

That a 91-year-old man was discharged from hospital following surgery, having refused to wait over the weekend for a care package to be put in place and there was no follow-up arranged to either assist him with his care or to ensure that he was coping.

Since receipt of your Regulation 28 Report, we have reviewed records in respect of Mr Kelly and his recent admission.

Mr Kelly attended the Emergency Department (ED) via his General Practitioner on 31 August. He was admitted with an incarcerated hernia and surgery was planned.

Mr Kelly went to theatre on 01 September and had an open right inguinal hernia repair. A urinary catheter was placed. His post-operative recovery was uneventful. On 02 September, the Consultant reviewed him in the morning and stated that he might be suitable for discharge if he managed following a trial without his urinary catheter. At noon, one of the hospital's Discharge Officers discussed Mr Kelly's home and social

history with him. Mr Kelly advised that he had no package of care, he had a partner who supported him, and he felt they could manage. He consented to the Discharge Officer contacting his partner to confirm that no further support was needed.

The Discharge Officer contacted Mr Kelly's partner who advised that she was happy for him to come home and could support him provided he was able to walk up the stairs. She also advised that there was no equipment at home, and she did sometimes have difficulty in showering / bathing Mr Kelly. The Discharge Officer advised that the therapy team would be asked to review Mr Kelly, and they would update her when there was further information.

The Discharge Officer asked a Registered Nurse to complete a referral for Physiotherapy. In the mid-afternoon, the physiotherapist assessed Mr Kelly: he managed a 'stairs assessment', was independent with bed mobility, transfers (from bed to chair, chair to standing etc…) and was walking independently without any mobility aids. Mr Kelly was given a 'useful numbers contact list' if he felt he needed any support following discharge. He was not felt to have any equipment needs. Mr Kelly was not judged to require a support / care package and nor did he seek such.

Shortly after 5pm, Mr Kelly's nurse documented a successful trial without urinary catheter. Bloods had been requested for the following morning (to review inflammatory markers, CRP) and the potential for discharge the next day was noted (depending on blood results). Of note, this was a day later than the Consultant's earlier suggestion.

On Saturday 03 September, a consultant reviewed Mr Kelly, noted a satisfactory CRP, and a plan was made for discharge that day assuming no specific home / social issues. A Discharge Officer contacted the Mr Kelly's partner once again, updated her on the outcome of the therapy assessment and advised that he could go home that day. She agreed to collect him when he was ready and did so shortly after 4pm.

The nursing records note that Mr Kelly was alert and orientated, independent and self-caring. He was given the useful numbers list if he felt he needed support post discharge.

While it is impossible not to be affected by the circumstances of Mr Kelly's death over two weeks later, we have not identified anything that we would seek to do differently in similar circumstances. An elderly gentleman received prompt surgical treatment and his discharge needs were subsequently explored with him and his family by

appropriate members of staff. Mr Kelly's functional ability was, with his agreement, assessed by a qualified therapist. The professional opinion was that no formal support was required. Signposting information as provided to Mr Kelly such that he would know where to go for support should his situation change.

Mr Kelly was judged to have mental capacity throughout his admission (from providing informed consent for surgical intervention, through to discharge planning). His self-autonomy was respected in line with his mental capacity. Importantly, Mr Kelly did not *'refuse to wait over the weekend for a care package'*: he was not judged to require a care package, nor did he or his partner seek one.

From the information that we have subsequently received, it seems that Mr Kelly's partner having a fall four days after his discharge may have been a key event: this could not have been predicted or averted by the hospital. The medical information that we hold at the hospital, in the round, did not point to significant psychiatric illness: the only pertinent entry was made in the Emergency Department some months prior where there is passing reference to Mr Kelly having started and quickly stopped an anti-depressant in the community.

I am conscious that discharge from hospital can be a challenging area, with widespread concern nationally around the availability of domiciliary support and funding of the same. On this occasion, I consider that hospital procedures functioned well and could not reasonably have foreseen subsequent events. It is unfortunate that a Regulation 28 Report was felt to be the appropriate route for us to share this information.

Yours sincerely,

[redacted]

[redacted]
Chief Executive