REGULATION 28: REPORT TO PREVENT FUTURE DEATHS

	REGULATION 28 REPORT TO PREVENT FUTURE **DEATHS THIS REPORT IS BEING SENT TO:** 1. **Chief Executive, Manchester City Council** 2. **Chief Executive, East Midlands Ambulance Service** 3. **Group Chief Executive Manchester University NHS Foundation Trust**
1	**CORONER** I am Lauren Costello, Assistant Coroner, for the Coroner Area of Manchester South
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	**INVESTIGATION and INQUEST** On 2nd June 2023 an investigation was commenced into the death of John Howe, then aged 81 years. The investigation concluded at the end of the inquest on 24th May 2024. At the end of the Inquest, I recorded a narrative conclusion that Mr Howe **d*ied as a result* of hospital acquired pneumonia against a background of necessary surgery to treat diabetic foot sepsis.**
4	**CIRCUMSTANCES OF THE DEATH** John Howe was an 81-year-old man with type 2 diabetes and peripheral vascular disease. His diabetes was not always controlled, and he had frequent episodes of high blood sugar. In December 2021 he started to experience issues with his foot including sepsis as a result of the diabetes and peripheral vascular disease. His foot deteriorated and by October 2022 he was advised that amputation was necessary, but he did not consent to this. During an admission on 28th April 2023, it was discovered that his condition had deteriorated, and he agreed to an amputation which took place on 10th May 2023 at Manchester Royal Infirmary. He was discharged home on 19th May 2023 but thereafter he deteriorated and was admitted to Stepping Hill Hospital, Poplar Grove Stockport on 23rd May 2023. Despite treatment he continued to deteriorate and died there on 28th May 2023 as a result of hospital acquired pneumonia against a background of necessary surgery to treat the diabetic foot sepsis and haemorrhage from the wound. The Inquest heard that when Mr Howe was discharged from hospital on 19th May 2023, and he was woken from sleep at 23:00 to be transported home meaning that he arrived at his home address in the early hours of the

	morning on 20th May 2023. His family were not aware that this was happening, access to his home was difficult, and it resulted in him being left outside whilst this was addressed. A serious Incident Review took place, and a report was prepared after a lengthy delay.
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** is as follows. – (1) The inquest heard that there has been a change in policy with regards to the timing of discharge of patients from Manchester Royal Infirmary in circumstances where a patient is unable to manage independently when they arrive home. However, the Inquest heard that late discharges were still happening. In addition, the Inquest heard that the East Midlands Ambulance Service were unaware of the change in discharge timings. (2) Completion of the Serious Incident Review was delayed, and the report contained factual inaccuracies, giving rise to a concern relating to the approach taken by Manchester City Council to Serious Incident Reviews.
6	**ACTION SHOULD BE TAKEN** In my opinion action should be taken to prevent future deaths and I believe you and 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 20th August 2024. 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] on behalf of the family and Stepping Hill Hospital . 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. 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	**DATE** **SIGNED BY CORONER** **25th June 2024** L. Costello