[redacted]

NHS
Stockport
NHS Foundation Trust

PRIVATE AND CONFIDENTIAL

Ms J Gill
HM Assistant Coroner
Coroner's Court
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SK1 3AG

[redacted]
Oak House
Stepping Hill Hospital
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Stockport
Cheshire
SK2 7JE

[redacted]

10 April 2026

Ref: Inquest touching on the death of Lesley Marie KROMMENDIJK
Date of Birth: 09/12/1945
Date of Death: 20/06/2025

Dear Ms Gill

Thank you for giving the Trust the opportunity to respond to the concern you raised regarding discharge processes from Stockport NHS Foundation Trust. You have raised the following matter of concern:

> The current processes for assessing whether or not it is safe to discharge a patient appear to have led to an unrealistic impression of the patient's mobility.

I have asked the Division of Women, Children and Integrated Community Services to review Mrs Krommendijk's discharge along with their usual practices and their response is as follows:

Mrs Krommendijk attended hospital on 31 May 2025 following a fall resulting in a fractured right hip. Mrs Krommendijk was subsequently transferred to Ward D5 where it was determined that no surgical intervention was required and that conservative management was advised with weight bearing as tolerated. Mrs Krommendijk had a therapy review on 2 June 2025. The records show that she had been independent with bed and chair transfers and was able to mobilise approximately 20 metres with a wheeled Zimmer frame (WZF) and close supervision. The therapy team ordered a commode and perching stool which Mrs Krommendijk's son was going to collect.

On 3 June 2025 Mrs Krommendijk was supported to attempt a stair assessment but was very anxious. Three steps were completed but she did not want to attempt a full flight of stairs. Therapy staff discussed with Mrs Krommendijk who stated she would discuss with her son regarding downstairs living and plan to have a bed downstairs as therapy staff were aware she had been sleeping on the sofa and advised against this.

Following the morning whiteboard round on 4 June 2025, inclusive of the whole multidisciplinary team, it was determined that Mrs Krommendijk was discharge ready and would require a Pathway 1 Home Based Intermediate Care assessment following discharge. A Discharge to Assess (D2A) referral was completed detailing all care and therapy needs. This is an agreed Greater Manchester D2A form. A Senior Occupational Therapist (OT) liaised with Mrs Krommendijk's son regarding discharge planning. It was agreed that Mrs Krommendijk would have a downstairs microenvironment set up with D2A input to support personal care, meal preparation and mobility progression. Mrs Krommendijk's son was to collect a commode and perching stool. A privately purchased bed was being delivered on 5 June 2025 and Mrs Krommendijk's son advised the OT he would be building the bed on that day. An Age UK referral was also sent for care call, pendant alarm provision.

An e-mail was sent from a Stepping Hill Ward Tracker to the Transfer of Care Hub (ToCH – the team which manage discharges) on 5 June 2025 at 12:01 to advise that Mrs Krommendijk had a suitable bed in place in the living room to facilitate downstairs living on discharge. Mrs Krommendijk was planned to be discharged on 5 June 2025 as she had an appointment at the Manchester Royal Infirmary. The plan was for her son to collect Mrs Krommendijk from Ward D5 and take her to the appointment then support with care until the D2A team performed their initial assessment on the morning of 6 June 2025.

Mrs Krommendijk was discharged from Ward D5 as planned into her son's care. At the time of discharge there was no discrepancy between the information within the referral to D2A and her function at the time.

On 6 June 2025 at 08:30 a Physiotherapist and a Band 4 Trusted Assessor (the D2A Assessors) from the D2A team performed a joint assessment of Mrs Krommendijk's needs in her property. This identified that Mrs Krommendijk would require four support calls a day with one member of staff to assist her with transfers and all activities of daily living. Mrs Krommendijk's son was present at the beginning of the assessment and provided access to the staff. Mrs Krommendijk was deemed to have capacity in making all decisions around her finances and health and wellbeing.

The care first took place at 12:50 and 17:30 for support with activities of daily living. No concerns were raised at that time. On 7 June 2025 at 09:50 a D2A senior support worker visited Mrs Krommendijk. She performed sit-to-stand from the bed to WZF independently. Her step-round transfer to wheelchair and settee was observed to be difficult with left foot movement restricted. She independently washed and dressed her upper half and was assisted with the lower half.

On 7 June 2025 at 11:30 Mrs Krommendijk received an assessment by an Intermediate Care at Home (ICaH) Nurse and OT, independent sit-to-stand transfers were observed from the settee; static commode use was assessed as independent but positioned unsafely due to being unsupported in open area of the room; alternative placement was discussed.

Short-term, realistic patient centred goals were agreed with Mrs Krommendijk. Discussion was had around previous and current ability levels to help guide focus of therapy. Bed transfers and personal care were noted as now requiring assistance of one to support. Mrs Krommendijk was deemed to be cognitively intact, however psychologically frustrated and resistant to some equipment recommendations.

The OT ascertained she was previously independent with walking aids, managing the stairs, and all activities of daily living. Mrs Krommendijk disclosed she was beginning to find completing the stairs difficult in the weeks prior to her admission and had begun to sleep on the settee. Mrs Krommendijk confirmed her family would support her with shopping and domestic tasks, and she had a cleaner employed to visit once every fortnight.

A Care Call alarm falls device was discussed, and Mrs Krommendijk consented to an Age UK referral to assist in arranging this. Further conversation was had around Mrs Krommendijk declining delivery of glideabout commode; however, she now accepted the need for this and a new delivery arranged. The OT also recommended installation of patient standing transfer equipment i.e. a ReTurn, which could be used as a backup if mobility continued to be limited.

A referral to the Reablement and Community Home (REaCH) Support team and the ICaH team was completed for ongoing rehabilitation and reablement.

Mrs Krommendijk remained on the D2A and ICaH service until 18 June 2025 when she transitioned over to REaCH.

Following a full review of Mrs Krommendijk's documentation whilst in hospital, during the discharge planning process and following her return to home, her mobility and function was continually reviewed as would be expected with appropriate equipment in place. Though Mrs Krommendijk declined physically following her discharge from hospital, the Divisional team believes her discharge was appropriately planned for and completed within our usual expectations. The D2A and ICAH team communicated with Mrs Krommendijk's GP throughout this period, ensuring that she had timely interventions as required.

We hope that the above addresses your concern and assures you that the Trust has taken this matter of highest importance. Please do not hesitate to contact me if you require any further information.

Yours sincerely

Chief Executive