

REGULATION 28: REPORT TO PREVENT FUTURE DEATHS

	<p>REGULATION 28 REPORT TO PREVENT FUTURE DEATHS</p> <p>THIS REPORT IS BEING SENT TO:</p> <p>Chief Executive of Stockport NHS Foundation Trust</p>
1	<p>CORONER</p> <p>I am Jyoti Gill, assistant coroner, for the coroner area of Manchester South</p>
2	<p>CORONER'S LEGAL POWERS</p> <p>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.</p>
3	<p>INVESTIGATION and INQUEST</p> <p>On 30 June 2025 an investigation commenced into the death of Lesley Marie Krommendijk, age 79. The investigation concluded at the end of the inquest on 7 November 2025. The conclusion reached at the inquest was as follows: Died as a consequence of complications arising from injuries sustained from unwitnessed falls at her home.</p> <p>The medical cause of death was:</p> <p>1a) Sepsis 1b) Pneumonia II) Peri-prosthetic right hip fracture, osteoporosis, peripheral vascular disease</p>
4	<p>CIRCUMSTANCES OF THE DEATH</p> <p>On 31st May Mrs Krommendijk had a fall at home where she slipped over her blanket. Mrs Krommendijk was taken to Stepping Hill Hospital where it was confirmed that she had fractured her right hip. The consultant stated that an injury of this nature would typically be managed conservatively (non-surgically) with weight-bearing as tolerated. Mrs Krommendijk was discharged home on 5th June.</p> <p>The team that discharged Mrs Krommendijk reported that she was mobile and fit for discharge. Mrs Krommendijk's son stated he has never seen his mother as mobile as was described by the hospital or the subsequent teams who cared for his mum at home. Mrs Krommendijk's son explained how he would frequently, with the assistance of his partner and his mum's neighbours, assist his mother up from the bed to the commode, following her discharge home on 5 June 2025, as she was unable to do this alone. This differed from the account provided by those that provided care to Mrs Krommendijk. I preferred the evidence of the family and am concerned that the discharge was too early and therefore potentially unsafe.</p> <p>The entries by the Discharge to Assess Team and those by the Intermediate Care Team and Physiotherapists do refer to the pain and difficulty which Mrs Krommendijk's experienced when trying to mobilise whilst at home. The Reach team who took over the support calls from 12 June 2025 have made no mention or reference to any mobility issues or pain which Mrs Krommendijk experienced from 12 to 16 June 2025.</p> <p>On 18th June, the Reach reablement team, who were visiting Mrs Krommendijk during a scheduled call, arrived at Mrs Krommendijk's house to find her lying on the floor.</p> <p>On 19th June Mrs Krommendijk's was admitted by ambulance to Stepping Hill Hospital as she appeared confused. Mrs Krommendijk's son had arrived at Mrs Krommendijk's</p>

	<p>home. When Mrs Krommendijk's arrived at hospital she had a chest x-ray which revealed patchy consolidation in her right lung field, blood tests showed a raised CRP and low sodium.</p> <p>Sadly, Mrs Krommendijk died on 20 June 2025 at Stepping Hill Hospital.</p>
5	<p><u>CORONER'S CONCERNS</u></p> <p>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.</p> <p>The MATTERS OF CONCERN are as follows. –</p> <p>(1) 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.</p>
6	<p>ACTION SHOULD BE TAKEN</p> <p>In my opinion action should be taken to prevent future deaths and I believe your organization has the power to take such action.</p>
7	<p>YOUR RESPONSE</p> <p>You are under a duty to respond to this report within 56 days of the date of this report, namely by 22nd April 2026. I, the coroner, may extend the period.</p> <p>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.</p>
8	<p>COPIES and PUBLICATION</p> <p>I have sent a copy of my report to the Chief Coroner and to the following Interested Persons: Mrs Krommendijk's son, Care Quality Commission who may find it useful or of interest.</p> <p>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.</p> <p>I may also send a copy of your response to any other person who I believe may find it useful or of interest.</p> <p>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.</p> <p>You may make representations to me, the coroner, at the time of your response, about the release or the publication of your response.</p>
9	<p>Jyoti Gill, Assistant Coroner</p> <p></p> <p>25th February 2026</p>