Regulation 28: Prevention of Future Deaths report

Thomas Charles TAYLOR (died 13.03.14)

	THIS REPORT IS BEING SENT TO: **1. [redacted]** **Medical Director** **Royal Free London NHS Trust** **Royal Free Hospital** **Pond Street** **London NW3 2QG**
1	**CORONER** I am: Coroner ME Hassell Senior Coroner Inner North London St Pancras Coroner's Court Camley Street London N1C 4PP
2	**CORONER'S LEGAL POWERS** I make this report under the Coroners and Justice Act 2009, paragraph 7, Schedule 5, and The Coroners (Investigations) Regulations 2013, regulations 28 and 29.
3	**INVESTIGATION and INQUEST** On 27 March 2014 I commenced an investigation into the death of Thomas Charles Taylor, aged 54 years. The investigation concluded at the end of the inquest earlier today. I made a narrative determination, which I attach to this letter.
4	**CIRCUMSTANCES OF THE DEATH** Mr Taylor was a diabetic who died in the Royal Free Hospital after a delay in the administration of insulin, following the loss of medical notes and drug chart.

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 will occur unless action is taken. In the circumstances, it is my statutory duty to report to you. The **MATTERS OF CONCERN** are contained within the narrative attached, but in brief - 1. The ward where Mr Taylor was being nursed seemed rudderless, operating without clarity of leadership or support. On 21 February, a bank nurse worked alone in the morning, though was joined by another agency nurse at lunch time, with only a senior nurse in the office. On 22 February, the nurse in charge appeared unclear that he had any additional responsibility by virtue of being the nurse in charge, other than to allocate nurses to patients. Despite only three nurses being on duty on 22 February, the nurse in charge took a break at the same time as another nurse. There was a conflict of views among the nurses that day about who had primary care of Mr Taylor. 2. There was no protocol for the loss of notes and drug chart. Attempts by the ward staff to locate these were not prompt, focused or sustained. The notes and chart were later found simply in a drawer on the ward. 3. When Mr Taylor refused to have his blood sugar checked, there seemed no well understood protocol for re-checking or escalation. Immediate provision was not made for the administration of insulin, and a doctor was even told that he was not diabetic. When Mr Taylor became significantly hyperglycaemic on the 22nd, after the administration of the delayed dose of insulin his nurses did not immediately re-check his blood sugar, perform neurological observations or alert medical staff.
6	**ACTION SHOULD BE TAKEN** In my opinion, action should be taken to prevent future deaths and I believe that 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 3 November 2014. 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 following. • HHJ Peter Thornton QC, the Chief Coroner of England & Wales • [redacted], daughters of Thomas Taylor • Professor Dame Sally Davies, Chief Medical Officer for England I am also under a duty to send the Chief Coroner a copy of your response. 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 Senior Coroner, at the time of your response, about the release or the publication of your response by the Chief Coroner.
9	**DATE** **SIGNED BY SENIOR CORONER** 01.09.14