REGULATION 28: REPORT TO PREVENT FUTURE DEATHS

	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO: The Chief Executive, Stockport NHS Foundation Trust.**
1	**CORONER** I am John Pollard, senior coroner, for the coroner area of South Manchester
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 31st January 2014 I commenced an investigation into the death of **Pamela Pattison** dob 13th May 1944.The investigation concluded on the 17th March 2015 and the conclusion was one of **a Narrative Conclusion**. The medical cause of death was 1a Aspiration Pneumonia following insertion of naso-gastric tube for nausea and vomiting consequent upon unstable diabetic control. 11. Brittle diabetes with diabetic nephropathy and diabetic neuropathy. Fractured neck of femur.
4	**CIRCUMSTANCES OF THE DEATH** **On the 6th January 2014 she fell at her home address and broke her hip. She was admitted to Stepping Hill Hospital and was operated on for her fractured femur. She had numerous co-morbidities including Type 1 Diabetes. On the 17th January her insulin doses were intentionally omitted due to mistaken assessment by one of the medical staff. She was cared for by relatively junior medical and nursing staff when in fact she ought to have been cared for in the HDU. As a result her diabetic care was sub-optimal and various failings led to her being nauseous and tending to vomit, leading to her developing aspiration pneumonia.**
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 as follows. **1. From the evidence it was apparent that nurse training on wards M4 and A11 was deficient and their understanding of the importance and danger of Type 1 Diabetes seemed to be limited at best. The nurses were unable to say why they had not escalated her care on a number of occasions.** **2. ALL the doctors in training need to be aware that they should not omit any dose of 'long-acting insulin'. The consultant expressed the 'hope' that they would know this, but the evidence suggested the contrary.** **3. It was evident that the nursing staff on, for example, the surgical wards, did not have any specialist outreach nurse advice on such things as diabetes.**

	4. **There was an obvious need for additional consultant cover for Diabetes. I was told that funding has been put in place to cover this, but as yet no one has been appointed to fulfil this vital role.** 5. **The specialist outreach Nurse Practitioner for diabetes was booked off sick for one month, and no 'cover' was in place to cover his absence.** 6. **There was either a lack of equipment or a lack of understanding by the staff as to what equipment was needed by them. The staff indicated that they were unable to find 'ketone dipsticks', for diabetic urine sampling. I was told that in fact these are unnecessary in that ketone blood tests are now routine. Similarly I was told they could not find any or sufficient cardiac monitors on the ward. Further evidence revealed there are in excess of 240 such monitors in the hospital but the relevant staff seemed unaware of this. They were also unaware that they could have used the ward based defibrillator for the same purpose.** 7. **There was a considerable delay of approximately 12 hours in moving her to ward A3 after this had been deemed the appropriate place for her to be. No reason for this delay was offered.** 8. **It was conceded by the 'Head of Risk' for the Trust, that there was a general under resourcing within the Trust for the care of patients with Diabetes**.
6	**ACTION SHOULD BE TAKEN** In my opinion action should be taken to prevent future deaths and I believe you 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 18th May 2015. 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 namely [redacted] **(son of the deceased)** . I have also sent it to **C.Q.C**. who may find it useful or of interest. 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 coroner, at the time of your response, about the release or the publication of your response by the Chief Coroner.
9	**23.3.15** **John Pollard, HM Senior Coroner**