REGULATION 28: REPORT TO PREVENT FUTURE DEATHS

	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO:** 1. **National Institute for Health and Care Excellence, London, 10 Spring Gardens, London, SW1A 2BU** 2. **Springfield House Care Home, Oaken Drive, Staffordshire WV8 2EE** 3. **[redacted], Bilbrook Medical Centre, Wolverhampton, WV8 1DX.**
1	**CORONER** I am Zafar Siddique, Senior Coroner, for the coroner area of the Black Country.
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 25 November 2014, I commenced an investigation into the death of Eliza Rebecca Bowen. The investigation concluded at the end of the inquest on 20 April 2015. The conclusion of the inquest was the deceased died on the 15 November 2014 from 1a. Hyperosmolar non-ketotic coma and this was a natural cause of death.
4	**CIRCUMSTANCES OF THE DEATH** 1. Eliza Bowen was admitted as a resident at the Springfield House Care Home on the 18 August 2014. She had a medical history including previous sub arachnoid haemorrhage, shunt in situ, hypertension and had suffered a CVA/stroke. Her medical needs were complex and she had limited communication and was fed via a gastrostomy or PEG tube. She was effectively immobile. 2. Her medication and care needs were managed and a detailed care plan was drawn up to cater for her needs. This also included regular contact with the General Practitioner for medical advice. There was no previous history of diabetes and previous blood glucose levels were within the normal range. 3. On the 15 November 2014, she became suddenly unwell and was admitted to New Cross Hospital, Wolverhampton with significantly raised glucose levels (97.7mmol/l). In hospital she was diagnosed with acute kidney injury and raised urea and creatinine. Despite medical intervention, she died as result of metabolic imbalances brought about by a dramatic increase in her blood glucose. This condition is called hyperosmolar non-ketotic coma and is recognised as a life threatening emergency in diabetics. 4. During the course of the inquest evidence emerged that she may have recently developed diabetes in the last few months before her death. Her family described that a few days before her admission to Hospital she appeared drowsy and sleepy and less responsive than normal. However her last recorded reading for blood glucose taken at Hospital on the 27.11.13 was raised when a reading of 9.9mmol/L was recorded. This may have been an indication of pre-diabetes condition and she had known risk factors including a BMI greater than 30.

	5. There was no follow up blood glucose monitoring throughout 2014 because there was no indication she was diabetic. However, she was regularly monitored throughout 2013 and for reasons which remain unclear no blood glucose tests were performed in 2014.
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. A simple blood glucose test done on a regular basis may have identified the diabetes sooner and the condition managed. 2. Although the patient wasn't identified as a diabetic she presented with some of the key associated risk factors including BMI greater than 30 and immobility due to her medical condition. 3. Consideration of specific medical guidance for management of patients and screening for diabetes in these circumstances should be made available to medical staff.
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 18 June 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, Mrs Bowen's family. 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	**22 April 2015** [redacted]