REGULATION 28: REPORT TO PREVENT FUTURE DEATHS (1)

	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO:** **The Chief Executive, Royal Berkshire Hospital Trust with a request that it be shared with other private hospitals that utilise similar policies.**
1	**CORONER** I am Peter James Bedford, Senior Coroner, for the coroner area of Berkshire
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** I conducted an Inquest into the death of Mr Michael Quinn that was heard at Reading Town Hall between the 27th and 30th July 2015. The conclusion of the Inquest was in the terms of a Narrative Conclusion attached to this report.
4	**CIRCUMSTANCES OF THE DEATH** Mr Quinn was a fifty-three year old gentleman who suffered from hypertension and type 2 diabetes and underwent a lumbar decompression procedure at the Circle Hospital, Reading on the 14th February 2013. He was discharged home on the 15th February but on the 20th February developed diarrhoea and vomiting symptoms. He was seen by his GP on the 21st February but was admitted to Frimley Park Hospital, Surrey on the 21st February when he presented as critically ill. Despite intensive treatment he passed away on the 4th April 2013.
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 could 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) Immediately prior to his surgery, Mr Quinn's blood sugar level was measured at 13mmol. This was made known to the treating surgeon and anesthetist who considered it appropriate to proceed with the surgery. It is recognised that raised blood glucose levels in diabetic patients increases the potential risk of infection. In the course of the evidence at the Inquest I heard that the hospitals guidance for acceptable levels of blood glucose levels in patients undergoing spinal surgery was no more than 15mmol. I understand that national guidance recommends a target blood glucose level of 6 to 10mmol with an acceptable level of between 4 and 12 mmol. I heard that other Hospitals Trusts do use a level of up to 15mmol but the root cause analysis report prepared on behalf of the Circle Hospital following Mr Quinn's death, included a recommendation that the hospital theatre department audit intra-operative blood glucose levels in patients based on a level of below 11mmol. I also heard in evidence that an American publication made reference to risk factors for infection with a pre-operative

	serum glucose level of greater than 6 to 9 and a post-operative level of 11.1mmol. I also heard that one hospital trust used a figure of 20 as the highest acceptable level and Diabetes Scotland quoted a level of 14mmol. (2) It is clear to me that there is a great deal of confusion about what is an appropriate level for patients such as Mr Quinn and the optimal blood glucose level that should be achieved in patients, diabetic or otherwise, prior to surgery. While I did not find at the Inquest that Mr Quinn's blood glucose level of 13mmol was a factor in the infection that led to his death, I am nevertheless concerned that the written policy in place at the time does not mirror that of the national guidelines and is also at odds with other published research articles. (3) I am directing this report to you because I understand that the method adopted by Circle Hospital was based on the policy of your Trust which took the lead in these matters. In those circumstances, I would invite the Trust to review its policy to determine whether the current recommended levels are appropriate in light of other current guidelines and evidence based research.
6	**ACTION SHOULD BE TAKEN** In my opinion urgent action should be taken to prevent future deaths and I believe your organisation has 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 Friday 25th September 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 family of Mr Quinn. You are 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	**3rd August 2015** **Peter J. Bedford** **Senior Coroner for Berkshire**