Stockport NHS
NHS Foundation Trust

Oak House
Stepping Hill Hospital
Poplar Grove
Stockport
SK2 7JE

Telephone: 0161 483 1010
Fax: 0161 487 3341
Direct line: 0161 419 5444
E-mail: [redacted]

Our ref. SLR - 133104
Your ref. JSP/KN/02688-2014

1 April 2016

H. M. Coroner
Greater Manchester South District
Coroner's Court
Mount Tabor
Mottram Street
Stockport
SK1 3PA

Dear Mr Pollard

Re: Steven Leslie ROGERS (Deceased)

I am writing in response to your regulation 28 report dated 20 January 2016 in which you write following the inquest into the death of the above named person. I am grateful to you for highlighting your concerns and for providing me with an opportunity to respond.

I shall address each of your concerns in the order in which you raised them to Stockport NHS Foundation Trust:

1. The doctor who discharged the patient from the hospital as being "medically fit for discharge" did so without ever seeing the patient. In his statement to the inquest he says "I am afraid I have never seen Mr Rogers...he was seen by two consultant colleagues...I was asked if he could go home by one of the nurses...was shown the notes...asked the nurse to follow the team's pre-arranged plan i.e. to discharge the patient. It is noted that Mr Rogers went home by bus". The fact that a doctor not only discharges a patient in this way but also has no compunction in saying that he has done so in a statement to a Coroner, suggests a fundamental lack of understanding as to the importance of ensuring that all factors are in place for discharge, including medical and social issues

It is normal practice for all patients to have a written plan by a consultant in relation to their discharge.

In this instance, a plan was put in place by an Acute Medicine Consultant in conjunction with a previous review by a Consultant Diabetologist and the Diabetes Nurse Specialist. It appears that this plan was adhered to in relation to the patient's ketones level which, when measured, was negative and therefore the plan for discharge was followed.

2. During his stay in the hospital, the staff had erroneously omitted to administer his Levemir long acting insulin. This was then given later but this meant that his regime had been altered and he would have to re-set the regime at home.

This dose was missed due to the ongoing issue of paper charts being used in the Emergency Department (ED) and the fact that the ED electronic system (AdvantisED) cannot interface with the electronic prescribing system (ePMA). The Diabetes Specialist Nurse prescribed Levemir on a paper chart whilst in ED. This chart was then mistakenly filed at the back of the patient's paper record on the ward and was therefore missed by nursing staff.

A risk assessment is already in place within the Trust regarding this issue and staff are reminded on all wards to check for any paper charts. The Trust is moving towards a Trust wide electronic patient record (EPR) which should resolve this issue, but in the meantime, I can confirm that there is a specialist "Task& Finish Group" in place to further review this issue and develop an effective interim solution. This group reports to the Trust's Risk Management Committee and through this to the Quality Governance Committee and the Quality Assurance Committee, which reports directly to the Board of Directors.

I am able to confirm that the potential serious incident investigation has been concluded. The outcome of the investigation and the agreement of the validation team was that there were no serious acts of omission or commission regarding the patient's care and as such this has not been deemed a Serious Incident. There are of course lessons that can be learnt and therefore there is an action plan associated with the report which we will share with you when it is finalised.

I hope that this response answers your concerns and provides you with the assurance that the Trust is committed to improving the quality of care we give to all our patients. Please do not hesitate to contact me if you have any further questions regarding this matter.

Yours sincerely

Ann Barnes
Chief Executive