HER MAJESTY'S CORONER
Blackpool & The Fylde

REGULATION 28: REPORT TO PREVENT FUTURE DEATHS

	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO: [REDACTED] Acting Chief Executive of Blackpool Teaching Hospitals NHS Trust**
1	**CORONER** I am Clare Doherty, Assistant Coroner, for the area of Blackpool and Fylde
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 02/03/2016 I commenced an Investigation into the death of **Barry THOMPSON,** aged **70** who was a retired painter and decorator living with his wife at 3 Washington Avenue, Blackpool. The Investigation concluded at the end of the Inquest on 29th September 2016 at Blackpool Town Hall. The medical cause of death was : 1a) Diabetic Ketoacidosis and Septicaemia 1b) Diabetic Foot Ulcers II) Long-term poor control of Diabetes Mellitus Peripheral Vascular Disease Obesity
4	**CIRCUMSTANCES OF THE DEATH** Mr Thompson, who was an insulin dependent diabetic, died at 02.14 on 27th February 2016,whilst he was a patient on the Acute Medical Unit (AMU) of Blackpool Teaching Hospitals NHS Foundation Trust. He had been transferred from the Emergency Department (ED) at 19.34 the evening before having been brought in by ambulance at 12.33. He was suffering from sepsis from diabetic foot ulcers and hyperglycaemia. Despite being at high risk of developing Ketoacidosis he was not given insulin, nor was his fluid infusion or his blood sugar monitored frequently. Crucially neither his blood nor urine was tested for Ketones after 16.15. He did not receive a repeat dose of antibiotics nor was he reviewed by a doctor on the AMU until found unresponsive at 0155. If these steps had been taken on the balance of probabilities Mr Thompson's death would have been avoided.

Coroner's Office, Municipal Buildings, P O Box 1066, Corporation Street, Blackpool, FY1 1GB
Tel: 01253 477128 Fax: 01253 477129

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. –

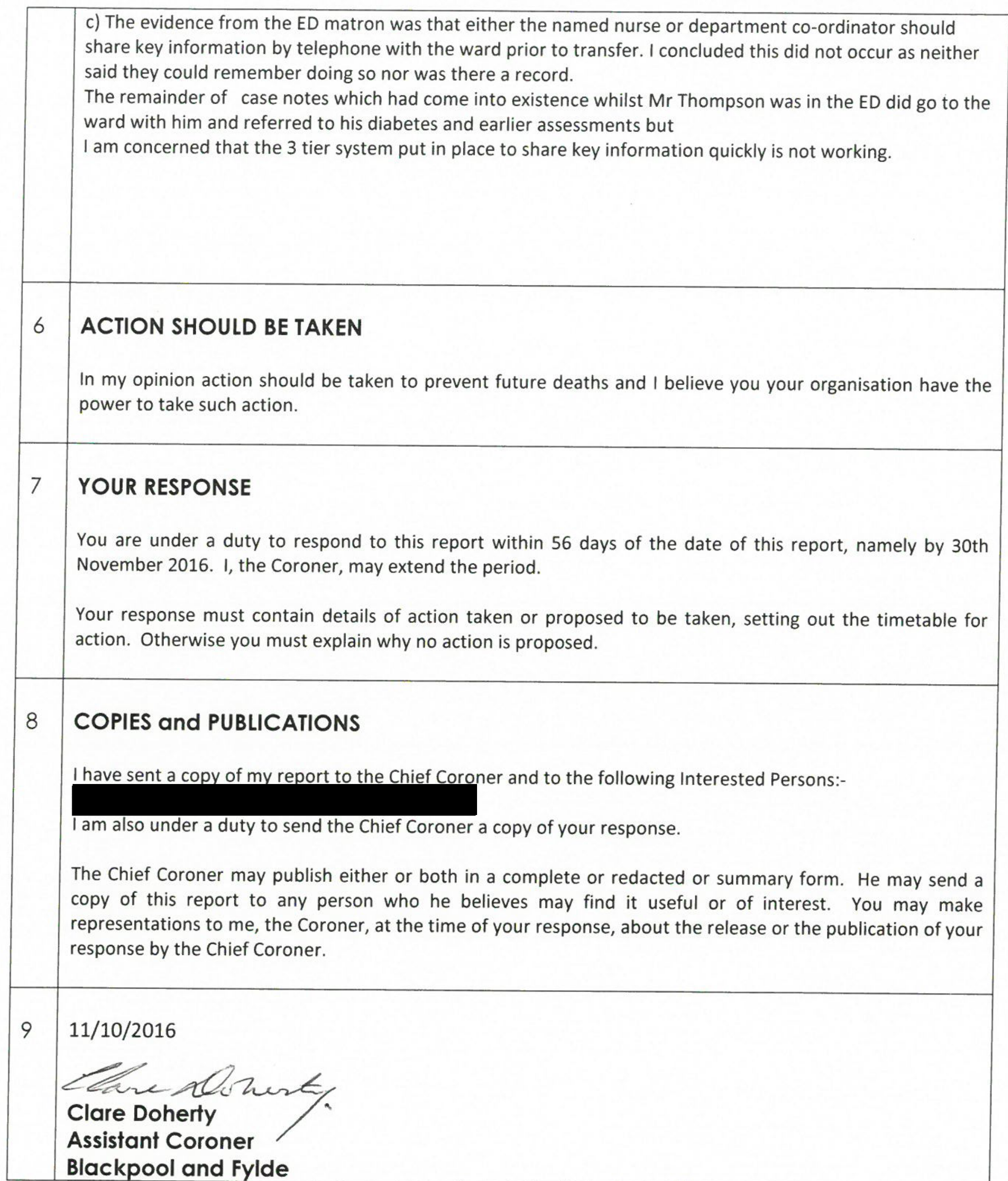
(1)Non-compliance with National and Local protocols:
Mr Thompson was triaged as a high priority on admission to the Emergency department at 12.37 am on 26th February 2016. It is recorded that he not had his morning insulin. He was not seen by a doctor nor given antibiotics within an hour according to the National Standard and the (Hospital's) Sepsis Pathway. He was seen by a doctor at 16.52 (although his case was drawn to the attention of a doctor earlier by a nurse and instructions given for care). Further a NEWS score of 7 (National Early Warning Score) was not actioned according to policy which would have resulted in Mr Thompson being reviewed by at least middle grade doctor immediately.

(2) Managing a diabetic patient.
Instructions were not given as to how frequently Mr Thompson's blood sugar and ketones should be monitored. The evidence was that this should be every hour. After 16.15 hours there was one measurement of blood sugar and a later recording on the acute medical unit (untimed) and no measurement of ketones. It is of concern that staff were not clear how frequently to monitor a diabetic patient, nor one with a concomitant condition i.e. sepsis, or where to locate a Ketone box for testing .Diabetes is a very common medical problem which hospital staff encounter frequently. Another inquest approximately 18 months ago was heard at Blackpool concerning the management of a diabetic patient where, although the facts and personnel differed the same conclusion was recorded. In that case the author of the Serious Incident Review concluded there was a lack of "joined up thinking".

(3)Monitoring patients' basic needs.
There was difficulty encountered giving Mr Thompson saline by way of a drip. He was given an infusion of 1 litre over 4 hours at 17.30. At 23.00 it was found that the original cannula had become detached but the remaining fluid in the sac was 700mls. Mr Thompson's bed was wet with saline fluid. He did not therefore receive the intended dose. He was not given a further injection of antibiotics 6 hours after the first nor was he written up for it. He was not given insulin. He does not appear to have been given any food whilst a patient or adequate fluid balance charts maintained. He was not seen by a doctor on the AMU. He was on a range of medication on admission to hospital for co-morbidities. The importance of this or otherwise was not assessed by staff.

(4) Record keeping. /**Information sharing**.
I found on hearing the evidence that records from both departments from 16.52 onwards are , inaccurate, infrequently made, disjointed and and incomplete causing them to be unreliable and affected continuity of care. Also this caused staff at the inquest not to be able to fully recall their actions.

There was a 3 stage system in place to ensure transfer of important information about Mr Thompson when he moved from the ED to the AMU.
a) A SBAR document is completed by the transferring nurse who accompanies the patient. In this case the document does not state (despite there being provision on the form) who that person was or who the receiving nurse was. It does not identify Mr Thompson as a diabetic nor state he has not had his insulin. It erroneously states he is not on a sepsis pathway.
b) There is a computerised tracking system providing for doctors in the ED to transfer key information about a patient to the doctors on the AMU. This then serves as a live reference point for staff on the ward. In this case the information refers to Mr Thompson having cellulitis only and makes no reference to his diabetes. This affected the prioritisation of Mr Thompson on the AMU particularly when it came to observations and testing needed and review by a doctor.



c) The evidence from the ED matron was that either the named nurse or department co-ordinator should share key information by telephone with the ward prior to transfer. I concluded this did not occur as neither said they could remember doing so nor was there a record.
The remainder of case notes which had come into existence whilst Mr Thompson was in the ED did go to the ward with him and referred to his diabetes and earlier assessments but
I am concerned that the 3 tier system put in place to share key information quickly is not working.

6 ACTION SHOULD BE TAKEN

In my opinion action should be taken to prevent future deaths and I believe you 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 30th November 2016. 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 PUBLICATIONS

I have sent a copy of my report to the Chief Coroner and to the following Interested Persons:-

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

11/10/2016

Clare Doherty
Assistant Coroner
Blackpool and Fylde