ANNEX A

REGULATION 28: REPORT TO PREVENT FUTURE DEATHS (1)

*NOTE: This form is to be used **after** an inquest.*

	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO:** **1. [redacted] - Operations Director of Adbolton Hall Nursing Home**
1	**CORONER** I am Jane Gillespie, assistant coroner, for the coroner area of Nottinghamshire
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 07.03.2018 I commenced an investigation into the death of Joan Osborne, aged 72. The investigation concluded at the end of the inquest on 20.03.2018. The conclusion of the inquest was natural causes contributed to by neglect.
4	**CIRCUMSTANCES OF THE DEATH** Joan Osborne went to live at Adbolton Hall Nursing Home on 19.10.2015. Mrs Osborne suffered from Type II diabetes, ischaemic heart disease, chronic kidney disease stage 4 and vascular dementia. Throughout her time at Adbolton Hall it was agreed by all professionals that there were ongoing difficulties with obtaining her blood glucose levels and administering her insulin prescription due to her non-compliance. This was a result of her dementia. She was subject to a deprivation of liberty order. Mrs Osborne required staff to obtain her blood glucose levels and assist with administering her daily insulin. Mrs Osborne was unable to be responsible for her own prescription. On 12.08.2017 Mrs Osborne was admitted to the Queens Medical Centre suffering from raised blood sugar levels of 42 mmol/L, dehydration and vomiting. In the previous 7 days; 05.08.2017 to 12.08.2017, Mrs Osborne had received just two doses of her required daily insulin prescription. Mrs Osborne had high blood ketones but was not acidotic. Mrs Osborne was discharged back to Adbolton Hall on 15.08.2017 having been treated with IV insulin. On 22.08.2017 Mrs Osborne was once again admitted to the Queens Medical Centre. She had been found by [redacted], GP, semi-conscious at the nursing home, during his usual Tuesday rounds. He had been asked by a staff member to see Mrs Osborne last, on a list of 7-8 residents. Mrs Osborne died on 25.08.2017. The cause of death was 1a. Diabetic Ketoacidosis 2. Advanced Dementia. Mrs Osborne had not been given her daily insulin on 20.08.2017, 21.08.2017 and 22.08.2017. The situation had not been escalated by the nursing home staff to a management level, nor had any medical attention been sought for Mrs Osborne. Mrs Osborne was given approximately 50 ml of Lucozade on the morning of 22.08.2017. A member of staff misread Mrs Osborne's blood glucose level at the point that [redacted] was present. It was reported as '4' but was in fact 'Error 4'. When checked by [redacted], the score was 'HI' meaning a reading of over 30. It does not appear that Mrs Osborne's blood glucose level was taken earlier in the day.

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) The nursing home staff did not seek assistance from the Dementia Outreach Team when Mrs Osborne's compliance with her blood glucose levels and insulin prescription deteriorated at the end of 2016 onwards. (2) The nursing home did not make any members of staff available for the pre-arranged appointment with the Diabetes Nurse on 28.11.2017 resulting in a missed opportunity to seek assistance with Mrs Osborne's compliance. (3) The nursing home staff did not seek medical assistance for Mrs Osborne when she refused to have her insulin prescription over an extended period, on two separate occasions, leading to her hospitalisation on 12.08.2017 and 22.08.2017. (4) The nursing home staff did not alert anyone in the management team to the fact that Mrs Osborne had refused to have her insulin prescription for a period of 3 days prior to her hospitalisation on 22.08.2017. (5) The nursing home records in respect of Mrs Osborne were inadequately completed. (6) The nursing home staff did not recognise the need, nor seek help, for Mrs Osborne's deteriorating condition on 22.08.2017 and did not seek the urgent attention of her GP upon his usual attendance at the home on that date. (7) Mrs Osborne was incorrectly given Lucozade on the morning of 22.08.2017 at a point when her blood glucose levels had not been obtained, and were 'HI'. (8) A member of staff at the care home was unable to accurately obtain Mrs Osborne's blood glucose level on 22.08.2017 when asked by the GP and did not recognise that the reading was incorrect.
6	**ACTION SHOULD BE TAKEN** In my opinion action should be taken to prevent future deaths and I believe you and/or 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 21.05.2018. 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: [redacted], [redacted] and [redacted] - Children of Joan Osborne [redacted] - Nottinghamshire Healthcare NHS Foundation Trust [redacted] - General Practitioner at Castle Healthcare Practice [redacted] – Care Quality Commission [redacted] - Rushcliffe Older Adults Team I have also sent it to the following persons who may find it useful or of interest: Nursing and Midwifery Council 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	 **Miss Jane Gillespie** **26.03.2018**