REGULATION 28: REPORT TO PREVENT FUTURE DEATHS

	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO:** **(1) Justin Hutchens, Chief Executive Officer, HC-One, Southgate House, Archer Street, Darlington DL3 6AH**
1	**CORONER** I am, Rachel Galloway, Assistant Coroner, for the Coroner Area of Manchester West
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 the 25th July 2018 an investigation was commenced into the death of Robert Charles Rostron, aged 72 years, born on the 9th May 1946. The investigation concluded at the end of the Inquest on the 3rd July 2019. The Medical Cause of Death was: 1a Sepsis 1b Pneumonia and Pyelonephritis 1c Alzheimers Disease II Type 1 Diabetes, Administration of insulin on 17th September 2017. The conclusion at the inquest was that Robert Rostron died as a consequence of natural causes, exacerbated by the administration of insulin on a background of Type 1 diabetes.
4	**CIRCUMSTANCES OF THE DEATH** 1. Robert Rostron (hereinafter referred to as "the Deceased") died at Fairfield General Hospital, Rochdale Old Road, Bury on the 20th July 2018. 2. The Deceased suffered from naturally occurring Type 1 Diabetes, for which he required regular monitoring and treatment. From mid-September 2017, he was a resident at the Four Seasons Nursing Home (which is a home under the management of HC One) on the Spring Unit (which is no longer in existence). As well as Type 1 Diabetes, the Deceased suffered from Alzheimers Disease and his position was such that he required nursing care and support in a nursing home environment. 3. On the 17th September 2017, an Agency Nurse was in charge of the Spring Unit. He started his shift shortly after 8 am. That member of staff was a qualified nurse, with experience in mental health matters but with limited experience of physical health matters. He was the only qualified nurse on duty on Spring Unit

(albeit that there were other nurses present on adjacent units). He was in charge of the shift, with the support of healthcare assistants. He was also in charge of giving prescribed medications to patients on Spring unit that day.

4. In evidence, the Agency Nurse confirmed that he had not worked on Spring Unit before. He had only ever undertaken one other agency-nursing shift, which was the day before and at a different place. On that occasion, he did have the support of another qualified nurse. On the 17th September 2017, he confirmed that he did not know where any of the patients' records were kept, he did not read the patients' records and he had no access to any care plans in respect of the patients he was caring for.

5. On the morning of the 17th September 2017, the Agency Nurse undertook the medication round. He had been shown where the medication was stored by a Healthcare Assistant and had been introduced to patients on the unit. During the course of the medication round (which he undertook alone), he had reference to the Deceased's medication record, which was stored by his bed. He did not have regard to the nursing records nor to any care plans contained therein, as he did not know where they were stored (they were apparently present in the nursing office). There was a care plan in place for the management of the Deceased's diabetes, but he did not have regard to that. He took the Deceased's blood sugar reading and noted this to be 2.2 (which is low). He then proceeded to give the Deceased what he considered to be his usual dose of insulin (8 units). This was not in accordance with the Care Plan in place and the evidence at the inquest was such that a qualified nurse would be expected to know that a reading of 2.2 units was a low reading and that insulin should have been withheld (and further measures taken, such as provision of a sugary drink to increase the blood sugar level).

6. It was not until a few hours later that the Agency Nurse checked again on the Deceased. By this stage, the Deceased was unconscious and unresponsive. An ambulance was called and he was taken to Royal Bolton Hospital. On the basis of the evidence heard, I concluded that the Deceased never recovered to his previous baseline. He spent time at two further nursing homes following his admission to Royal Bolton Hospital before being admitted to Fairfield Hospital on the 25th June 2018. On the basis of the clinical evidence heard, it was my finding that the events of the 17th September 2017 caused increased frailty and indirectly contributed to the Deceased's death. I found that the Deceased never regained his previous baseline and the administration of insulin on the 17th September was the cause of that. It made him more susceptible to the infections that he developed and led to his death on the 25th June 2018 at Fairfield Hospital. He would not have died when he did, but for the insulin administration on the 17th September 2017.

5 **CORONER'S CONCERNS**

During 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.

During the inquest, evidence was heard that (at nursing homes under the control of HC One):

1. Agency Nurses are still used – if needed – to lead a shift, when they have never worked on the unit before.

2. An Agency Nurse might still be the only qualified member of nursing staff on duty on the unit.

3. There is reliance upon a nursing qualification and the agency providing the

	Agency Nurse regarding nursing ability, suitability and training. 4. In this instance, the only induction to the Unit was by way of a Healthcare Assistant showing the Agency Nurse around on the morning of the shift. 5. The Agency Nurse did not appreciate the relevance of the blood sugar level of 2.2. 6. The Agency Nurse did not appreciate that no insulin should have been given in light of the reading of 2.2. 7. The Agency Nurse did not know where the nursing records were, the care plans for the patients or the relevant policies and procedures in place. 8. The Agency Nurse did not know that it was the policy of Four Seasons Nursing Home that insulin should only have been given by him, whilst a Healthcare Assistant was present to check the dose. I am concerned by the use of Agency Nurses in the homes under the management of HC One. In particular, I am concerned by the lack of formal induction and orientation to the unit on this occasion. I am concerned that reliance is placed upon the nursing qualification itself and the agency providing the nurse. I am concerned that an Agency Nurse was used as the senior member of staff in charge of the shift. I am concerned that the Agency Nurse was giving out medication when he had never worked at the Unit before and. I am concerned that there were no other qualified nurses on the Spring Unit at the time. I request that HC One conducts a review of the use of Agency Nurses in their homes
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 5th September 2019. I, the assistant 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: (1) [redacted] (2) HC One – Justin Hutchens, Chief Executive, HC-One, Southgate House, Archer Street, Darlington DL3 6AH (3) CQC (North) – [redacted] Inspector, Care Quality Commission (North, Adult Social Care, Manchester. 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 assistant coroner, at the time of your response, about the release or the publication of your response by the Chief Coroner.

9	**Dated 11th July 2019**
	Signed: **Rachel Galloway** **HM Assistant Coroner** **Manchester West**