Regulation 28: Prevention of Future Deaths report

Michael Anthony JAGGS (died 16.01.21)

	THIS REPORT IS BEING SENT TO: **Chief Executive** **MedPure Healthcare** **Stockley Park** **4 Long Walk Road** **Uxbridge UB11 1FE**
1	**CORONER** I am: Coroner ME Hassell Senior Coroner Inner North London St Pancras Coroner's Court Camley Street London N1C 4PP
2	**CORONER'S LEGAL POWERS** I make this report under the Coroners and Justice Act 2009, paragraph 7, Schedule 5, and The Coroners (Investigations) Regulations 2013, regulations 28 and 29.
3	**INVESTIGATION and INQUEST** On 28 January 2021, I commenced an investigation into the death of Michael Jaggs, aged 72 years. The investigation concluded at the end of the inquest on 21 September 2021. I made a determination at inquest as follows. Michael Jaggs was admitted to hospital on 15 January 2021 and treated for hyperkalaemia. He developed hypoglycaemia as a complication of this treatment. The agency nurse looking after him failed to escalate his deterioration to doctors, and he died from the hypoglycaemia. He was suffering from several chronic co-morbidities, but his death occurred when it did as a direct consequence of the failure to escalate his condition for medical attention.
4	**CIRCUMSTANCES OF THE DEATH**

	Mr Jaggs was looked after by a nurse from your agency. By 3am on 16 January 2021, he had a blood sugar level of 1.9 and the agency nurse did notify the nurse in charge, who instructed her to bleep a doctor to prescribe dextrose. The agency nurse told me that either she did not hear that instruction or she did not act upon it. In any event, she did not bleep that doctor, or any of the others available. By 3.45pm, when the nurse in charge was able to leave her patient and take off the full personal protective equipment she had been wearing, she found from the agency nurse that Mr Jaggs' blood sugar had dropped to 1.2 and he was unresponsive.
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. The agency nurse accepted in court that she should have sought prompt medical attention for Mr Jaggs and that she should have made a contemporaneous medical record of all his blood sugar readings. However, despite this sub optimal care, she said that she has not received any additional training from you following the incident. And she said that you did not ask her to draft a reflective statement, as the hospital trust had several times requested that you arrange. The trust has undertaken a great deal of work with its own staff to reduce the likelihood of such a failure in the future. I am extremely concerned that no similar learning is taking place within your agency.
6	**ACTION SHOULD BE TAKEN** In my opinion, action should be taken to prevent future deaths and I believe that 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 6 December 2021. 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 following. • [redacted], Michael Jaggs' daughter • Homerton University Hospital NHS Trust • Care Quality Commission for England • HHJ Thomas Teague QC, the Chief Coroner of England & Wales I would have copied this report to the regulator of nurse agencies, but I have not received details of that organisation from Homerton University Hospital and my office has been unable to identify it. I am also under a duty to send a copy of your response to the Chief Coroner and all interested persons who in my opinion should receive it. I may also send a copy of your response to any other person who I believe may find it useful or of interest. 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.
9	**DATE** **SIGNED BY SENIOR CORONER** 06.10.21 *ME Hassell*