Her Majesty's Coroner for the
Northern District of Greater London
(Harrow, Brent, Barnet, Haringey and Enfield)

North London Coroners Court,
29 Wood Street,
Barnet EN5 4BE

Telephone 0208 447 7680
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	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO:** 1. **Barnet and Chase Farm Hospitals NHS Trust** Wellhouse Lane, Barnet, Herts EN5 3DJ 2. Copy to:- **Department of Health** Department of Health Richmond House 79 Whitehall London SW1A 2NS
1	**CORONER** I am Andrew Walker, senior coroner, for the coroner area of Northern District of Greater London
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 2nd day of April 2013 I opened an investigation into the death of Grace Mary Bates, aged 93 years old. The investigation concluded at the end of the inquest on the 16th December 2013. The conclusion of the inquest was " Grace Mary Bates died on the 21st April 2013 in hospital as the result of complications from poorly managed diabetic episodes", the medical cause of death was complications of diabetes mellitus.
4	**CIRCUMSTANCES OF THE DEATH** Mrs Bates presented to the On the 29th March 2013 having been referred by her own doctor having become unwell during the previous week. Mrs Bates was continued on her regime of medication for her diabetes. There was no specialist diabetic nurse available over the weekend (beginning on the 20th April 2013) and the management of Mrs Bates blood sugar levels was poor during this period. Mrs Bates died in hospital from the complications of poorly managed hypoglycaemic episodes on the 21st April 2013.

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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) That should be a specialist diabetic nurse available over the weekend at the hospital.
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 Monday 7th April 2014. 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 members of the family. 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	**7th January 2014** **Coroner Andrew Walker** **Senior Coroner**