	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO:** 1. **County Durham and Darlington NHS Trust, Darlington Memorial Hospital, Hollyhurst Road, Darlington DL3 6HX**
1	**CORONER** I am Andrew Tweddle Senior Coroner, for the coroner area of County Durham and Darlington
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. (see attached sheet)
3	**INVESTIGATION and INQUEST** On 30th July 2013 I commenced an investigation into the death of PATRICIA LILLIAN CHAPMAN, Aged 77 years. The investigation concluded at the end of the inquest on 21st April 2015 The conclusion of the inquest was "The avoidable consequence of an avoidable hypoglycaemic episode". with a cause of death of Hypoglycaemia.
4	**CIRCUMSTANCES OF THE DEATH** The deceased was a patient at Sedgefield Community Hospital. In the afternoon of the 8th of July 2013 she had a severe Hypoglycaemic attack but following an injection, apparently recovered. In the early morning of the next day she died from another Hypoglycaemic attack. The inquest has revealed a number of shortcomings with regard to the deceased's care. Many changes in practice policy and procedure have been implemented since her death.
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) The revised training and flow chart does not include any reference to staff in a community hospital being able to obtain emergency advice from an expert in the emergency department of one of the Trust's acute hospitals (or from an expert in another department of the said hospitals if appropriate) to assist in giving immediate medical cover whilst, for example, other steps are being taken or whilst an ambulance is on route after having been summoned. It may well be the case that in urgent situations immediate medical advice from an appropriate expert might be beneficial when trying to ensure a patient's safety and this is not included in the revised Trust policies. This is something that should be given consideration to.
6	**ACTION SHOULD BE TAKEN** In my opinion action should be taken to prevent future deaths and I believe 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 18th June 2015. 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] and the CQC. 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	**23 April 2015** [redacted] **Andrew Tweddle LLB** **HM Senior Coroner** **County Durham and Darlington**

SCHEDULE 5 paragraph 7

ACTION TO PREVENT OTHER DEATHS

1)Where—

(a)a senior coroner has been conducting an investigation under this Part into a person's death,

(b)anything revealed by the investigation gives rise to a concern that circumstances creating a risk of other deaths will occur, or will continue to exist, in the future, and

(c)in the coroner's opinion, action should be taken to prevent the occurrence or continuation of such circumstances, or to eliminate or reduce the risk of death created by such circumstances,

the coroner must report the matter to a person who the coroner believes may have power to take such action.

(2)A person to whom a senior coroner makes a report under this paragraph must give the senior coroner a written response to it.

(3)A copy of a report under this paragraph, and of the response to it, must be sent to the Chief Coroner.

Regulations 28 and 29

Report on action to prevent other deaths

28.—(1) This regulation applies where a coroner is under a duty under paragraph 7(1) of Schedule 5 to make a report to prevent other deaths.
(2) In this regulation, a reference to "a report" means a report to prevent other deaths made by the coroner.
(3) A report may not be made until the coroner has considered all the documents, evidence and information that in the opinion of the coroner are relevant to the investigation.
(4) The coroner—
(a) must send a copy of the report to the Chief Coroner and every interested person who in the coroner's opinion should receive it;
(b) must send a copy of the report to the appropriate Local Safeguarding Children Board (which has the same meaning as in regulation 24(3)) where the coroner believes the deceased was under the age of 18; and
(c) may send a copy of the report to any other person who the coroner believes may find it useful or of interest.
(5) On receipt of a report the Chief Coroner may—
(a) publish a copy of the report, or a summary of it, in such manner as the Chief Coroner thinks fit; and
(b) send a copy of the report to any person who the Chief Coroner believes may find it useful or of interest.

Response to a report on action to prevent other deaths

29.—(1) This regulation applies where a person is under a duty to give a response to a report to prevent other deaths made in accordance with paragraph 7(1) of Schedule 5.
(2) In this regulation, a reference to "a report" means a report to prevent other deaths made by the coroner.

(3) The response to a report must contain—
(a) details of any action that has been taken or which it is proposed will be taken by the person giving the response or any other person whether in response to the report or otherwise and set out a timetable of the action taken or proposed to be taken; or
(b) an explanation as to why no action is proposed.
(4) The response must be provided to the coroner who made the report within 56 days of the date on which the report is sent.
(5) The coroner who made the report may extend the period referred to in paragraph (4) (even if an application for extension is made after the time for compliance has expired).
(6) On receipt of a response to a report the coroner—
(a) must send a copy of the response to the report to the Chief Coroner;
(b) must send a copy to any interested persons who in the coroner's opinion should receive it; and
(c) may send a copy of the response to any other person who the coroner believes may find it useful or of interest.
(7) On receipt of a copy under paragraph (6)(a) the Chief Coroner may—
(a) publish a copy of the response, or a summary of it, in such manner as the Chief Coroner thinks fit; and (b) send a copy of the response to any person who the Chief Coroner believes may find it
useful or of interest (other than a person who has been sent a copy of the response under paragraph (6)(b) or (c)).
(8) A person giving a response to a report may make written representations to the coroner about—
(a) the release of the response; or
(b) the publication of the response.
(9) Representations under paragraph (8) must be made to the coroner no later than the time when the response to the report to prevent other deaths is provided to the coroner under paragraph (4).
(10) The coroner must pass any representations made under paragraph (8) to the Chief Coroner who may then consider those representations and decide whether there should be any restrictions on the release or publication of the response.