REGULATION 28: REPORT TO PREVENT FUTURE DEATHS

REGULATION 28 REPORT TO PREVENT FUTURE DEATHS THIS REPORT IS BEING SENT TO: The Chief Executive, Stockport NHS Foundation Trust: 1 CORONER I am John Pollard, senior coroner, for the coroner area of South Manchester 2 CORONER'S LEGAL POWERS I make this report under paragraph 7, Schedule 5, of the Coroners and Justice Act 20 and regulations 28 and 29 of the Coroners (Investigations) Regulations 2013 3 INVESTIGATION and INQUEST On 27 th August 2015 I commenced an investigation into the death of Steven Leslie Rogers dob 15 th July 1969. The investigation concluded on the 13 th January 2016 and the conclusion was one of Natural Causes. The medical cause of death was 1a Diabetic Keto-acidosis 1b Type 1 Diabetes Mellitus. 4 CIRCUMSTANCES OF THE DEATH This man was admitted to Stepping Hill Hospital on the 20 th August 2015 via the E.D. at 11.21am: he had been sent by his GP who had noted reduced consciousness and confusion in a man who was known to be a fairly unstable	
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Type 1 Diabetic. He was admitted to the wards and overnight he was to have, int alia, his long acting Levemir insulin. This was accidentally omitted. The following day he was discharged as medically fit, by one of the consultants who had never seen the patient, and he was found dead at home two days later, having died from Diabetic Keto-acidosis.	9
5 CORONER'S CONCERNS	\dashv
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 taken. In the circumstances it is my statutory duty to report to you.	s
The MATTERS OF CONCERN are as follows. — 1. The doctor who discharged the patient from the hospital as being "medically fit for discharge" did so without ever seeing the patient. In his statement to the inquest he says "I am afraid I have never seen Mr Rogers I was asked if he could go home by one of the nurseswas shown the notes asked the nurse to follow the team's pre-arranged plan i.e. to discharge the patient. It is noted that Mr Rogers went home by bus". The fact that a doctor not only discharges a patient in this way but also has no compunction in saying that he has done so in a statement to a Coroner, suggests a fundamental lack of understanding as to the importance of ensuring that all factors are in place for discharge, including medical and social issues.	•
2. During his stay in the hospital, the staff had erroneously omitted to	

	administer his Levemir long acting insulin. This was then given later but this meant that his regime had been altered and he would have to re-set the regime at home.
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 16 th March 2016. 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 namely (sister of the deceased and his next-of-kin). I have also sent it to CQC and who may find it useful or of interest.
	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	20.1.16 John Pollard, HM Senior Coroner