REGULATION 28: REPORT TO PREVENT FUTURE DEATHS (1)

	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO:** **1.** Secretary of State Department of Health
1	**CORONER** I am Simon Nelson Senior Coroner for the Coroner area of Manchester North
2	**CORONER'S LEGAL POWERS** I make this report under paragraph 7, Schedule 5, of the Coroner's and Justice Act 2009 and Regulations 28 and 29 of the Coroners (Investigations) Regulations 2013
3	**INVESTIGATION and INQUEST** On the 22nd of January 2015 I commenced an investigation into the death of Natalie Ann Thornton then aged 29 years. The investigation concluded at the end of the inquest on 2 February 2017. The conclusion of the inquest was Natural Causes–the medical cause of death being diabetic ketoacidosis
4	**CIRCUMSTANCES OF DEATH** Natalie Thornton was diagnosed with type 1 diabetes at the age of 3 years. Her long-standing diabetic control was described as 'brittle' with history of recurrent diabetic ketoacidosis exacerbated by diabetic nephropathy leading to chronic kidney disease; advanced diabetic eye disease and delayed stomach emptying. Her blood glucose control had always been highly variable. With a view to improving the quality of her life it was decided on the 2 December 2014 to start her on insulin pump therapy for which she was deemed competent and adequately prepared. At some time after 11:00 hours on 18 January 2015 Natalie awoke and complained of feeling unwell. She subsequently collapsed in the bathroom; deteriorated rapidly and by the time of the arrival of the first paramedic at approximately 14:44 hours CPR was being undertaken without there being any electrical activity in the heart. The fact of death was subsequently confirmed at 15:32 hours that day
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. Concern was expressed as to the adequacy of the monitoring and review of blood sugar levels/data generated following the initial use of the pump provided by the Salford Royal Trust which provided Natalie's equipment and had been caring for her over many years. More particularly trends were not analysed. Whilst noting that the introduction of insulin pump therapy was deemed an evolutionary process no formal Pump Agreement was in place at the time although such Agreements have now been implemented 2. From the evidence given by the expert Consultant [redacted] it would appear that the level of support for insulin pump users nationally is variable. Whether the need for consistency and minimum standards should be addressed by Regional Centres of

	Excellence would be a matter for the Department to consider.
6	**ACTION SHOULD BE TAKEN** **In my opinion action should be taken to prevent future deaths and I believe each of you respectively 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 . 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:- 1. Insulet Corporation 2. North West Ambulance Service 3. Family of Natalie Ann Thornton 4. Salford Royal Foundation Trust 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 from. He may send a copy of this report to any person who he believes may find it usefulor 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	Date: 6 February 2017 Signed: Simon Nelson HM Senior coroner