Regulation 28: REPORT TO PREVENT FUTURE DEATHS

NOTE: This form is to be used **after** an inquest.

	REGULATION 28 REPORT TO PREVENT DEATHS **THIS REPORT IS BEING SENT TO:** [redacted] Executive NHS Leicester Leicestershire and Rutland Integrated Care Board
1	**CORONER** I am Miss F BUTLER, Her Majesty's Assistant Coroner for the coroner area of Rutland and North Leicestershire.
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 30 June 2021 I commenced an investigation into the death of Colleen Alice FLETCHER aged 82. The investigation concluded at the end of the inquest on 30 June 2022. The conclusion of the inquest was natural causes.
4	**CIRCUMSTANCES OF THE DEATH** Colleen Fletcher was diagnosed with Type 2 diabetes in 1999. She was insulin dependent. Due to her underlying condition of Alzheimer's disease, Mrs Fletcher was cared for in a residential care home and her insulin was managed daily by the community nursing team. On 26 January 2021, Mrs Fletcher's blood glucose levels began to rise and continued to do so over the course of the next few days, measuring 13.2 mmols on the 27 January and 17.2 mmols on 28 January. It did not respond to the prescribed insulin doses which were being administered. Mrs Fletcher was not referred to the GP or the Diabetic Specialist Nurse. On 29 January 2021 Mrs Fletcher's blood glucose level was 29.6 mmols. She became hyperglycemic and collapsed. An ambulance was called but Mrs Fletcher went into a diabetic coma before the Ambulance arrived and sadly passed away at 10.31 hrs on 29.01.2021 at the Hinckley Park Care Home.
5	**CORONER'S CONCERNS** During the course of the investigation my inquiries revealed matters giving rise to concern. In my opinion there is a risk that future deaths could occur unless action is taken. In the circumstances it is my statutory duty to report to you. The **MATTERS OF CONCERN** are as follows: I understand that patients who have volatile glucose levels have the availability of pre-issued prescriptions for rapid acting insulin.

	Those patients, like Mrs Fletcher, whose glucose levels are relatively stable don't have the availability of the same prescription. Should their glucose levels begin to rise they would have to be referred to a GP, reviewed by that GP, possibly asked to monitor further and/or a prescription issued and collected from the surgery/chemist, before increased insulin could be administered. I was told that this could take in excess of a 24 hour period, during which time a patient's glucose levels could continue to rise. I was told that raised glucose levels in and of themselves would not be considered an emergency for the ambulance service until a patient went into a state of hyperglycaemic collapse, which, as in the case of Mrs Fletcher, was a point of no return. I understand that discussions are taking place to ensure the availability of fast acting insulin to be prescribed for <u>all</u> patients who are diabetic (regardless of volatility in their blood glucose levels) and that whilst progress has been made for those whose readings are volatile there is still work to be done to have the standby provision of bolus injections available for patients otherwise stable, whose glucose levels could at any point become unstable (by contracting an infection for example). I consider that this is an essential tool for nurses on the front line to have at their disposal in treating effectively rising glucose levels and preventing hyperglycaemia and subsequent death.
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 14 September 2022. 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: Family of Mrs Fletcher Leicestershire Partnership Trust Hinckley Park Care Home Care Quality Commission 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 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 by the Chief Coroner.

9	**Dated: 20 July 2022**  **Miss F Butler** **Her Majesty's Assistant Coroner for Rutland & North Leicestershire**