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	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO: The Chief Executive Maidstone & Tunbridge Wells NHS Trust**
1	**CORONER** I am Roger Hatch Senior Coroner for **North West Kent**
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. http://www.legislation.gov.uk/ukpga/2009/25/schedule/5/paragraph/7 http://www.legislation.gov.uk/uksi/2013/1629/part/7/made
3	**INVESTIGATION and INQUEST** On 19th December 2018 I commenced an investigation into the death of Jonathan Richard McCARTHY. The investigation concluded at the end of the inquest 30th April 2019. The conclusion of the inquest was The deceased died on the 7th October 2018 at the Tunbridge Wells Hospital, Tunbridge Road, Pembury, Tunbridge Wells, Kent. 1a **Diabetic Ketoacidosis and Hypertensive Heart Disease** b **Diabetes Mellitus** c II **Peripheral Vascular Disease, Hypertension, Cerebral Infarction**
4	**CIRCUMSTANCES OF THE DEATH** Jonathan McCarthy was admitted to the hospital on 29/8 - unwell, increased confusion and erratic BMS No drowsiness - Family advised chesty breathing and felt as if fluids were going wrong way. He had two previous episodes of aspiration pneumonia post stroke. Treated for sepsis 2nd to Aspiration pneumonia and AKI. SALT review noted as moderate oropharyngeal dysphasia with aspiration event likely. Erratic BM's controlled with variable rate insulin. Required optiflow and suctioning and chest physio to improve oxygenation. Also noted to have Cdiff on admission NG fed in interim while poor swallow - Monitored by SALT, physio and dieticians regularly. Slow improvements noted. He was weaned off optiflow - Erratic BM during admission requiring variable rate insulin infusion with adjusting. Deteriorated again with another aspiration pneumonia requiring Cpap/optiflow and physio. medication escalated to suit. Regular diabetic team input regarding BM's - variable rate insulin. Ongoing NG feeding - he was too weak to be able to sit up in a chair for videofluoroscopy - Ongoing regular chest physio - On 5/10 seen by consultant and insulin increased. Over the weekend noted to be hyperglycaemic - No escalation documented in note. DNAR put in place Patient found with no cardiac output at 06:00 hours on 7/10
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. – [BRIEF SUMMARY OF MATTERS OF CONCERN] (1) The Trust failed to correctly monitor the blood sugar and ketone testing of Jonathan Richard McCarthy (2) The Trust failed to administer the correct does of insulin (3) There was inadequate nursing care and a failure to escalate to the medical team when it was clear this should be carried out.

6	**ACTION SHOULD BE TAKEN** In my opinion action should be taken to prevent future deaths and I believe you Chief Executive 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 17th July 2019. 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 Thompson, Snell & Passmores. I have also sent it to Keith McCarthy 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	22nd May 2019 Signature:  Roger Hatch Senior Coroner **North West Kent**