Regulation 28: REPORT TO PREVENT FUTURE DEATHS

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REGULATION 28 REPORT TO PREVENT DEATHS

THIS REPORT IS BEING SENT TO **The Chief Executive**
James Paget University Hospital
Lowestoft Road
Great Yarmouth
Norfolk
NR31 6LA

1 CORONER

I am Yvonne BLAKE, Area Coroner for the area of Norfolk

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 25 November 2019 I commenced an investigation into the death of Pauline Russell aged 61. The investigation concluded at the end of the inquest on 31/07/2020. The conclusion of the inquest was a narrative conclusion as follows:

Mrs Pauline Russell died at the James Paget Hospital, Lowestoft Road, Gorleston, Norfolk on 22 November 2019 from Aspiration Pneumonia following her collapsing in a hypoglycemic coma. Mrs Russell had been injecting a higher incorrect dose of insulin since her discharge from hospital on 11 November 2019.

The Medical Cause of Death is

1a Aspiration Pneumonia
1b Hypoglycaemic Coma

2. Insulin Dependent Diabetes Mellitis, Previous stroke.

1 CIRCUMSTANCES OF THE DEATH

Mrs Russell, a poorly controlled diabetic, was admitted to the James Paget Hospital, Gorleston, Gt. Yarmouth on 6/11/19 with a history of falls, and a urinary tract infection. She took amongst other things, insulin twice daily**. Her insulin was increased to 64 units** twice daily and she was discharged on 8/11/19 on this regime. Neither [redacted] or Mrs Russell can read or write. Mrs Russell went home first, and her husband returned to the hospital to collect her medication. He was given a bag of medication and saw a letter inside. The staff nurse gave evidence that he went through Mrs Russell's medications with [redacted] using the discharge letter as reference. In any event **Mrs Russell told her husband when he returned home that the doctor had increased her insulin to 92 units twice daily.** [redacted] queried this, but she was adamant that is what she had been told. The correct dose to be given was listed on the discharge summary which neither could read. Mrs Russell received 5 days of 92 units of insulin B.D. [redacted] drew it up in the pen because Mrs Russell had cataracts and she injected it herself. On the morning of the 17/11/19 a carer arrived, and Mrs Russell was unresponsive and so she began resuscitation and called an ambulance. Mrs Russell was given glucose by paramedics which slightly improved her condition, but she did not wake up. Life support was withdrawn, and Mrs Russell died on 22/11/19.

2 CORONER'S CONCERNS

The MATTERS OF CONCERNS are as follows: That no-one checked whether Mrs Russell could read, her admission pack has a long section on communication but not once is the question asked can you read/write or something of that nature. Mrs Russell would have been given menus to select from and been expected to read

other things whilst in hospital, but nobody checked that she could do this. On discharge no one checked that [redacted] could read and understand the discharge summary. **The inquest was 8 months after Mrs Russells' death and when I asked the nurse who discharged her about his current practice around patients being asked about literacy his reply was "I'm thinking about it" so even a death had not altered his practice.** The hospital has not introduced anything during this long period of time to ascertain if their patients can read/write. I appreciate that it can be embarrassing to ask the staff and patient, but it is vital that if people are being discharged home with written instructions, they can read them to check those instructions, or be shown in a different way what the instructions are, eg. a diagram, getting a relative to read them or a carer. I find it surprising that nothing has been done on the hospital's own initiative in 8 months and I remain concerned that a similar incident may occur again.

3 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.

4 YOUR RESPONSE

You are under a duty to respond to this report within 56 days of the date of this report, namely by 29 September 2020. 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.

5 COPIES and PUBLICATION

I have sent a copy of my report to the Chief Coroner and to the following Interested Persons:

[redacted] (Spouse)

I have also sent it to:
Department of Health
Care Quality Commission
Healthwatch Norfolk
HSIB, 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. Dated: 04 August 2020

Yvonne BLAKE
Area Coroner for Norfolk
Norfolk Coroner Service
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Norwich NR1 2TN