REGULATION 28: REPORT TO PREVENT FUTURE DEATHS

	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS THIS REPORT IS BEING SENT TO: The Greater Manchester Health and Social Care Partnership
1	CORONER I am Alison Mutch, Senior Coroner, for the Coroner Area of Greater Manchester South
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 29th October 2021 I commenced an investigation into the death of Darren Jones. The investigation concluded on the 6th June 2022 and the conclusion was one of **Narrative: Died from the complications of necessary catheterisation**. The medical cause of death was **1a) Sepsis; 1b) Urinary Tract Infection on a background of long term catheterisation; II) Chronic bladder outflow obstruction, Chronic Kidney Disease**
4	CIRCUMSTANCES OF THE DEATH Darren Jones had severe learning disabilities and lacked capacity. He had a long term catheter fitted after developing urinary retention. He had chronic kidney disease as a consequence of his history of urinary retention. He was admitted to Stepping Hill Hospital following three unsuccessful attempts to change his catheter in the community. Further attempts in the Emergency Department were unsuccessful and he was admitted to Stepping Hill Hospital. At 10:04 on 21st October 2021 he had a NEWS2 score of 8. At 11:38 he was placed on the sepsis pathway on patient track and intravenous antibiotics given. He deteriorated throughout the day despite treatment. On 22nd October 2021 he died at Stepping Hill Hospital from sepsis.

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. The Inquest heard that delivering care in the community to Mr Jones in relation to his catheter care was impacted by the significant demands on the District Nursing Team due to their staffing levels against their caseload. The evidence was that the District Nursing Teams were under significant pressure which impacted the support and care they could deliver; 2. Mr Jones had significant learning difficulties which were not fully recognised at the hospital to ensure that he was provided with support and that an IMCA was put in place to ensure his best interests were met. The Inquest heard evidence that it was important that all clinicians and health care professionals were clear and understood how to effectively support someone with a learning disability to ensure they were given the best and most appropriate care; 3. The Inquest heard that there was a dispute between two Local Authorities regarding training in catheter care. This impacted the provision of respite care and his health and wellbeing; 4. No LeDeR appeared to have been commissioned on the evidence before the Inquest.
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 11th 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 namely 1) [redacted] Mr Jones' Carer/Guardian; 2) Stepping Hill Hospital, 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	**Alison Mutch OBE** **HM Senior Coroner**  **17.07.2022**