REGULATION 28: REPORT TO PREVENT FUTURE DEATHS (1)

	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO:** **1. Rt Hon Victoria Atkins, Department of Health And Social Care, 39 Victoria Street, London, SW1H 0EU**
	CORONER I am Joanne Kearsley, 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 21st December 2022, I commenced an investigation into the death of Raymond Horace Watkins. Raymond Watkins died on the 28th November 2022 at Royal Oldham hospital. The investigation concluded on the 26th June 2024. The medical cause of death was confirmed as 1a) Septicaemia 1b) Insulin controlled Type 2 Diabetes, Chronic Obstructive Pulmonary Disease, Ischaemic Heart Disease, Pressure Ulcers 2) Cerebrovascular Accident
4	**CIRCUMSTANCES OF DEATH** Mr Watkins had been admitted to hospital on the 4th November 2022. During this admission he was placed on end of life palliative care and his usual medications including his insulin were stopped. He was discharged from hospital on the 10th November 2022 to his care home. The following day Mr Watkins advised the home, his GP and others that he wanted to restart his medications including his insulin. At this stage Mr Watkins had capacity and his clinical picture had improved. The GP prescribed his insulin and the authorisation required by the District Nurses for them to administer the same. The court heard that an authorisation is required before District Nurses can administer the same. Due to administrative errors both within the GP practice and the District Nurse practice this prescription was not authorised before Mr Watkins was readmitted to hospital on the 22nd November 2022. An initial forensic post mortem had considered the medical cause of death to be directly attributable to the lack of insulin however further expert evidence concluded that the prescribing of further insulin would, in this case not have been appropriate and in any event would not have made any difference. The cause of death was therefore revised. However it was acknowledged by all Interested Persons and the expert that the breakdown in communication between the GP and District Nurses was indefensible and could in a different case have been causative. As a result of their investigation into this case the Northern Care Alliance has developed and rolled out across 4 areas of Greater Manchester a "Time Critical Medicine" process for District Nurses advising them as to which medicines are considered time critical and what steps to take if authorisations are not correctly completed on receipt. This includes: - Contacting the Prescriber and immediately raising a datix incident

	- Returning to the prescriber within 2 hours if correct authorisation is not received - Escalation by end of shift to a manager - Escalation following morning to the Assistant Director of Nursing The implementation of this Standard Operating Procedure which came into place in March 2024, led to the number of datix incidents increasing significantly, highlighting the widespread issue. However since its implementation this has raised the awareness amongst GPs and prescribers of errors and the numbers have declined dramatically to the point where practices are making real differences to the ability for patients to access such medicines.
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. During the course of the evidence the court heard that receipt of correct authorisations in respect of medicines is an issue faced by District Nurses in many areas of the country. Currently there is no "Time Critical Medicine" guidance for the community setting.
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 **21 August 2024.** 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:- - Family of Mr Watkins - Northern Care Alliance - Abbeycare Care Home - The Alexandra Group Medical Practice 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 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	Date: 26/06/2024 Signed: