	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO:** **NORTHAMPTON GENERAL HOSPITAL NHS TRUST**
1	**CORONER** I am Jonathan Dixey, assistant coroner, for the coroner area of Northamptonshire.
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 18 January 2023 an investigation was commenced into the death of Mr Leslie Hurwood. On 5 February 2025 the inquest hearing began and is due to conclude tomorrow (6 February 2025).
4	**CIRCUMSTANCES OF THE DEATH** Mr Hurwood died on 13 January 2023 at Kettering General Hospital. He had a history of Type I diabetes mellitus (from 1969), hyperlipidaemia, hypothyroidism, glaucoma and essential hypertension. He had recently been diagnosed with dementia. Until 2022 his diabetes was well-managed.
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 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. – In December 2022 Mr Hurwood was an in-patient at Northampton General Hospital. This followed a fall at home. During this admission he suffered multiple episodes of hypoglycaemia. Mr Hurwood's insulin medication was to be provided by nurses within the hospital. I have heard evidence from a Diabetes Specialist Nurse at the Diabetes Centre at Northampton General Hospital that on 12 December 2022 Mr Hurwood was referred by ward staff for a diabetes review. The Diabetes Specialist Nurse explained in evidence that she observed that nurses (plural) were administering Mr Hurwood's insulin after meals. She advised the nurses that Mr Hurwood's insulin should be provided before his meals. In evidence, the Diabetes Specialist Nurse told me: a. Insulin should be administered prior eating. b. Its effectiveness is reduced if not administered before eating. c. This was not the only time that she was aware that nurses at Northampton General Hospital were (incorrectly) administering insulin to patients after they had eaten their meals. d. This continues to happen "occasionally": the most recent episode which she had directly encountered occurred in the last 2 to 3 months. e. Whilst the Diabetes Centre members have had discussions with nurses and training does occur "the message does get through for some people". The

	implication – which she agreed was the correct implication – was that the "message" did not get through to other nurses. A former Ward Sister at Northampton General Hospital has also given evidence at the inquest. She agreed that staff must get insulin administration correct. She thought the incorrect administration of insulin after a meal "probably does happen". She accepted that there was "no excuse" for this, but pointed to the possible contributory effect of a lack of staff.
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 3 April 2025. 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: 1. Mr Hurwood's family. 2. Kettering General Hospital NHS Foundation Trust. 3. Northamptonshire Healthcare NHS Foundation Trust. 4. St Matthews Healthcare. 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	**JONATHAN DIXEY** **5 February 2025**