REGULATION 28: REPORT TO PREVENT FUTURE DEATHS

NOTE: This form is to be used **after** an inquest.

REGULATION 28 REPORT TO PREVENT FUTURE DEATHS

THIS REPORT IS BEING SENT TO:

1. High Meadows Care Home

1 CORONER

I am Mr Andrew Walker, HM senior coroner for the coroner area of Northern London

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 the 22 July 2025 I commenced an investigation into the death of, Brian Lloyd, aged 78. The investigation concluded at the end of the inquest on 21 October 2025. The conclusion of the inquest was Consequences of infection following injury during catheter insertion at a care home. The medical cause of death was 1a Septicemia, 1b Urinary Tract Infection, 1c Insertion of urethral catheter.

4 CIRCUMSTANCES OF THE DEATH

On the 18th July 2025 Mr Brian James Lloyd died in hospital from an infection following injury caused by the insertion of a urethral catheter.

Mr Lloyd awoke as usual on the 12th July 2025 at his care home and all was well until his catheter became blocked. This was between 9.30 and 10.42.

A nurse attempted to flush the catheter which was not successful and the catheter was removed. There followed 2 attempts to insert a new catheter. Each of these attempts was not successful and as Mr Lloyd was distressed he was given paracetamol to ease his discomfort.

A third attempt was made at 15.40 which was also unsuccessful.

A call was then made to the London Ambulance Service at 16;26 and this was transferred to the London Central Urgent Care Center for a clinician to call the care home.

There were 3 attempts to call the care home with a connection being successful on the 4th attempt and an ambulance was arranged to take Mr Lloyd to hospital at 17;27.

When at hospital the doctors found some difficulty in inserting a catheter until

using a more specialised piece of equipment usually only available at a hospital.

Despite treatment Mr Lloyd was not able to recover from the infection that arose from the insertion of the catheter and it is likely that the blood seen on the 3rd attempt at inserting the catheter at the care home was the point at which the infection was able to spread.

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. -

Where there are two attempts at inserting a replacement catheter, either the same catheter, or a second catheter and both these are unsuccessful the patient will need to be taken to hospital and arrangements for this should be made as without delay.

6 ACTION SHOULD BE TAKEN

In my opinion action should be taken to prevent future deaths and I believe your organisation has 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 Monday 29th December 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. London Ambulance Service
- 2. The family.

I am also under a duty to send a copy of your response to the Chief Coroner and all interested persons who in my opinion should receive it.

I may also send a copy of your response to any other person who I believe may find it useful or of interest.

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.

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	9	DATE: 3 rd November 2025
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