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.** Central London Community Healthcare NHS Trust
1	**CORONER** I am Mr Andrew Walker, 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 29 September 2025 I commenced an investigation into the death of, Asher Blackman, aged 72. The investigation concluded at the end of the inquest on17 December 2025. The conclusion of the inquest was consequences of diabetes.
4	**CIRCUMSTANCES OF THE DEATH** On the 21st September 2025, Asher Blackman died in hospital having collapsed at his home, where he was found to be profoundly hypoglycaemic. It is unclear why he became so hypoglycemic as no District Nurse visited the evening before to provide his insulin injection. It is likely than an imbalance between his food and insulin caused the hypoglycaemia. Had the District Nurse been able to get access to Mr Blackman, a blood sugar reading would have been taken and an opportunity to treat Mr Blackman was therefore missed.
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. – That the initial assessment for Mr Blackman by the District Nurses did not record his next of kin details or what to do should the district nurse not be able to gain access. The policy following no access did not take into account the need for police involvement where the life of the patient may be at risk through non access.

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 Friday 01 May 2026 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. 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.
9	**DATE: 06 March 2026**