In response to HM Senior Coroner for Inner North London's Regulation 28 Prevention of Future Death (PFD) Report of 7 May 2021 concerning Mr Macaulay Wilson

Following the inquest touching on the death of Mr Wilson, HM Senior Coroner for Inner North London, Mary Hassell, concluded that Mr Wilson's death was as a result of urosepsis secondary to a failure to change his indwelling catheter for almost a year, when it should have been changed every 12 weeks. The medical cause of death was confirmed as 1a urosepsis and 1b long term indwelling catheter not changed since October 2019.

Concerns were raised within a Regulation 28 PFD report to Lower Clapton Group Practice on the manner and accuracy with which important information - passed from the specialist team to the GP practice - was then communicated to the district nursing team responsible for the delivery of the proposed treatment plan in relation to Mr Wilson's indwelling catheter. The Coroner noted in particular a loss of detail at the point when a practice GP conveyed the specialist team's instructions of 18 February 2019, such that the words catheter 'care' replaced the words catheter 'change'.

On behalf of Lower Clapton Group Practice, the practice partners Dr [redacted] and Dr [redacted] would like to express their deepest condolences to the family and friends of Mr Wilson. The practice notes the seriousness of these events and in response has undertaken the following activities to prevent a recurrence.

Lower Clapton Group Practice has introduced a system to ensure that when the practice receives correspondence containing instructions directed towards other members of the wider clinical team involved in a patient's care, such as district nursing, the relevant instructions will be clearly highlighted and a copy of the original letter will accompany any onward referral to ensure there is no loss of information or message clarity. We are undertaking an audit of all patients who have catheter products on their prescriptions. We will ensure that we clearly record in their notes how frequently their catheter should be changed and which service is responsible for doing this. We have written an electronic template within our clinical system to aid us in capturing the above data. This will be completed for all patients with a new indwelling catheter to ensure we have accurate information in connection with catheter care, catheter change frequency and the identity of the responsible team. We have written an electronic alert which activates when a patient is identified as being in receipt of catheter products (from their prescription page). This will prompt users to check for when a patient's catheter was last changed and identify which part of the service holds responsibility for this.

We have communicated the above to all members of the team including the person responsible for coding incoming patient related correspondence and these processes have been incorporated into our induction program. We have informed our local medicines management team about this case to ensure they can disseminate this risk within their monthly newsletter so that other practices can ensure a similar event does not occur. We have reported the incident via the National Reporting and Learning System and have informed the CCG. We are amending the City and Hackney wide EMIS template which is used when visiting housebound and vulnerable patients to include parameters such as catheters and catheter change as well as other issues which may increase patient risk such as pressure sores and falls.

A report has also been be passed to the CQC, expanding on these activities.

Lower Clapton Group Practice is grateful for the opportunity the Regulation 28 report has provided to review and strengthen our processes. We hope these activities will not only reassure HM Senior

Coroner of our commitment to delivering safe care but also Mr Wilson's family and the wider community we serve.

Dr. [redacted]

GP Principle

Date 24th June 2021.

Dr. [redacted]

GP Principle

Date 24th June 2021.