REGULATION 28: REPORT TO PREVENT FUTURE DEATHS (1)

	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO:** **1. [redacted] & Partners, Croft Shifa Health Centre, Bellfield Road, ROCHDALE**
1	**CORONER** I am Julie Mitchell, Assistant 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 18 July 2023 an investigation into the death of Zulfiqar HUSSAIN was commenced. The investigation concluded at the end of the inquest on 12 October 2023. The conclusion of the inquest was drug related and the cause of death was: 1a Combined drug toxicity 1b - 1c - II Bronchopneumonia
4	**CIRCUMSTANCES OF DEATH** Zulfiqar Hussain was 48 years old at the time of his death. He suffered with mental health issues and was receiving mental health care from the community mental health team. He was also a chronic illicit substance user and had received regular support from Turning Point. On 2 April 2023, the deceased was found at his home address having died from combined drug toxicity leading to significant respiratory depression, which was compounded by the presence of pneumonia. It was not possible, on the evidence available, to determine whether the deceased had ingested the drugs with the intention of ending his life. During the course of the inquest, the Court heard evidence about correspondence sent to the GP practice by Turning Point and the Mental Health Team. An adverse medication marker should have been prominently placed on the deceased's electronic medical records as a result of correspondence from Turning Point. However, this was not done. There were at least 2 occasions when correspondence from the mental health team should have prompted a clinical review by a clinician. These did not take place and the Court heard that this was most likely because the correspondence was filed by administration staff without it having been seen by a clinician. Whilst the evidence does not reach the requisite standard to show that the deceased's death would have been averted had correspondence been reviewed by clinicians at the GP practice, it meant that opportunities to provide the deceased with support and care and to foster his engagement with health services were missed. It is regrettable that this Court has previously issued a Regulation 28 report to your practice on the lack of robust processes to ensure clinician review of correspondence and, despite assurances, the situation in which correspondence is filed by administration staff without any clinician review pertains (see Regulation 28 report dated 23 December 2021).
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) As previously raised in Report to Prevent Future Deaths dated 23 December 2021, incoming correspondence to the GP practice continues to be dealt with by administrative staff who decide whether or not it is placed before a GP. The concern is that there is no robust system in place to ensure that communication to the surgery which may require action to be taken by medical staff is brought to their attention. (2) Adverse medication markers are not being placed on computerised medical records and this creates the risk that contraindicated medications may be inadvertently prescribed.
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 Friday 19 January 2024. I, the Assistant 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:- • The family of the Deceased • Turning Point • The Care Quality Commission • The GM Integrated Care Partnership 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.
-	Date: 24.11.23 Signed: