REGULATION 28: REPORT TO PREVENT FUTURE DEATHS (1)

	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO:** **1. [redacted] Chief Executive Northern Care Alliance** **2. [redacted] Chief Executive Pennine Care NHS Trust**
	CORONER I am Joanne Kearsley, Senior 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 the 23rd January 2023, I commenced an investigation into the death of Donna Marie Donnellan. The investigation concluded on the 25th September 2023. The medical cause of death was confirmed as 1a) Sudden death on a background of malnutrition 2) Peripheral Neuropathy. I recorded a narrative conclusion that Donna died as a result of complications arising from malnutrition likely due to an atypical eating disorder which was undiagnosed at the time of death.
4	**CIRCUMSTANCES OF DEATH** The deceased, Donna, had a long standing history of disordered eating which was characterised by her restricting her diet to certain types of food. In January 2021 she attended North Manchester General Hospital with leg weakness and poor appetite. Donna was diagnosed with peripheral neuropathy and remained in hospital for several weeks before being discharged to an intermediate care unit until the 5th March 2021. As a result of her peripheral neuropathy her mobility declined and she required a zimmer frame and subsequently a wheelchair. It was identified that she required assistance with care including meal preparation. Whilst initially accepting help it was eventually declined and she became increasingly reliant on her family. By September 2022 the Donna's weight had reduced to 25kg with a BMI of 10 and she was admitted to Fairfield General hospital. She remained an inpatient from the 16th – 28th September 2022. During this admission her weight increased however insufficient consideration was given as to whether she had an atypical eating disorder. During this admission Donna was seen by the Mental Health Liaison Team who concluded that she did not fit the criteria for anorexia and did not appear to have an eating disorder in accordance with the MEED guidance. The court heard a medical doctor disagreed with this assessment and felt Donna did have an eating disorder. However due to a belief that the Mental Health Liaison Team were "specialists", this view was overruled. Donna should have been referred to the Willows Eating Disorder Service. In addition there should have been a timely referral to the community dieticians. On the 3rd October 2022 the deceased was re-admitted to Fairfield General Hospital with a history of not having eaten for three days, weight loss and chest pain. The medical notes from her previous

	admission were not available to the treating clinicians. MEED guidance was not followed and she was not seen by a dietician. She should not have been discharged home on the 6th October 2022. She was found deceased at her home address on the 10th October 2022.
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) There was a lack of understanding between the Acute Trust clinicians and the Mental Health Trust as to the role of the Mental Health Liaison Team. Clarity is required as to whether the MHLT when asked to review a patient by the acute clinicians are reviewing so as to (i) make a diagnosis of an eating disorder or (ii) assess and assist in the consideration as to whether the Mental Health Act can be used to treat someone if they are refusing treatment. 2) There was a lack of understanding as to the pathways available to the acute clinicians for making a referral / seeking advice from the Specialist Eating Disorder Service ie the Willows.
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 25th January 2024. 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 namely:- Family of Donna Donellan 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.
9	Date: 30 November 2023 Signed: