REGULATION 28: REPORT TO PREVENT FUTURE DEATHS (1)

	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO:** **1. Co-Chairs of the Greater Manchester Integrated Care Partnership**
	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 22nd April 2024, I commenced an investigation into the death of Beverley Stanisauskis who died on the 18th January 2024. The investigation concluded on the 22nd July 2024. The medical cause of death was confirmed as 1a) Acute Respiratory Distress Syndrome 1b) Aspiration Pneumonia and Influenza Pneumonia 2) Gastrointestinal Bleeding and Breast Cancer The conclusion of the Inquest as that Mrs Stanisauskis died as a result of natural causes.
4	**CIRCUMSTANCES OF DEATH** Mrs Stanisauskis had been admitted to Fairfield General Hospital on the 4th January 2024 from her home address. She was suffering from shock due to a significant blood loss as a result of a gastrointestinal bleed. It was also likely she was suffering from pneumonia as a result of Influenza and likely aspiration. She was transferred to the Intensive Care Unit at the Royal Oldham hospital where despite appropriate treatment she died on the 18th January 2024. On admission to hospital there was evidence of self-neglect although this was likely to have been unintentional and linked to her learning disability. At the time of her admission to Fairfield General Hospital her medical conditions were advanced and it was unlikely she would survive. In addition it was believed that she had a carcinoma of the breast which was visible and that she had not sought treatment for the same. Mrs Stanisauskis had a learning disability. She resided at home on her own. She could not read and write particularly well. She was reluctant to speak to family and contact was sporadic. Evidence suggested she had not left her home very much since 2011. Evidence revealed she needed assistance with a number of aspects of daily living including prompts as to when to shower. She did not go shopping although she could cook. Despite this she had never been referred to the community learning disability team and received no support in respect of her medical issues. She had not been seen by her GP practice for 10 years. Following the death of Mrs Stanisaiskis the GP practice who she was registered with conducted a Serious Event review and noted the lack of engagement with the practice and the length of time she had not been seen. Importantly they also reviewed their links with the learning disability team.
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 recognition in the primary care setting that the patient's known learning disability may have been a factor in their lack of engagement. No attempts were made to speak to or for a doctor to the patient and there was a lack of involvement from the learning disability team.
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 16th October 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 Mrs Stanisauskis 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: 21/08/2024 Signed: