REGULATION 28: REPORT TO PREVENT FUTURE DEATHS

	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS THIS REPORT IS BEING SENT TO: Greater Manchester Integrated Care
1	CORONER I am Alison Mutch, Senior Coroner, for the coroner area of South Manchester
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 5th August 2024 I commenced an investigation into the death of Nisren ABDUL-KARIM. The investigation concluded on the 19th August 2024 and the conclusion was one of Narrative: **Died from natural causes contributed to by the complications of an accidental fall sustained whilst unobserved as an inpatient. The medical cause of death was 1a) Hospital acquired pneumonia 1b) Frailty 1c) End stage neurodegenerative condition II) Fall (1st Nov) requiring surgery for hip fracture (2nd Nov), Behcet's disease.**
4	CIRCUMSTANCES OF THE DEATH Nisren Abdul-Karim had a number of underlying health conditions including Behcet's disease. In Autumn 2023 she began to hallucinate. She was admitted again to Wythenshawe Hospital on 21st October 2023. She was a high falls risk. Whilst an inpatient and unobserved she had a fall. She should not have been unobserved. She was operated on for a fractured hip sustained in the fall. She was transferred to Trafford General Hospital for rehabilitation on 10th November. The transfer meant that access to neurology was more difficult because the service provided by neurologists was not available at Trafford General Hospital. She continued to deteriorate at Trafford General Hospital. Further advice was sought via patient pass from the neurology team at Salford Royal Hospital. Review of the scans previously undertaken concluded that she had irreversible neurodegenerative disease. She continued to deteriorate and died at Trafford General Hospital on 5th January 2024.
5	<u>CORONER'S CONCERNS</u> 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. – The evidence before the inquest was that the neurology service based at Salford Royal Hospital provided a service across Greater Manchester. However the notes kept by the neurology team were not stored on the patient's notes but recorded on patient pass. This meant accessing the notes required recognising that patient pass needed to be accessed. In addition the evidence was that the detail within the neurology notes on patient pass was very limited and meant that it was difficult to fully understand the neurology advice given or the contact that there had been with neurology. As a consequence delivery of neurology care was disjointed and meant there was no clear neurology overview held by neurology. This impacted on the care that could be provided to patients and the provision of advice to other clinicians. Illustrative of this one neurologist was unaware that it was one of their neurology colleagues had diagnosed a neuro degenerative disease. This is exacerbated in relation to sites such as Trafford Hospital where all contact with neurology is via telephone or patient pass as there is no face to face neurology service.
6	ACTION SHOULD BE TAKEN In my opinion action should be taken to prevent future deaths and I believe you 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 by 6th November 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 Manchester University NHS Foundation Trust, [redacted] on behalf of the family, who may find it useful or of interest. 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 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 by the Chief Coroner.

9	**Alison Mutch** **Senior Coroner**  **11/09/2024**