OFFICE OF THE
SENIOR CORONER
for the County of West Yorkshire
(Eastern District)

His Majesty's Coroner's Office
The Coroner's Courts
Burgage Square
Wakefield WF1 2TS

Telephone: [REDACTED]
Email: [REDACTED]

REGULATION 28: REPORT TO PREVENT FUTURE DEATHS

	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO:** **1. General Medical Council** **2.** [REDACTED]
1	**CORONER** I am Kevin McLoughlin, Senior Coroner, for the Coroner area of West Yorkshire (East)
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 12th November 2024 I commenced an investigation into the death of Fahmida Khanam, 74. The investigation concluded on 16th January 2025. The conclusion of the investigation that the death was due to natural causes, specifically: 1a Myocardial infarction 1b Severe coronary artery atheroma 2 Hypertension, asthma, diabetes mellitus, chronic kidney disease
4	**CIRCUMSTANCES OF THE DEATH** Mrs Khanam died on 12th November 2024. A post mortem attributed her death to natural causes. It emerged that her husband, [REDACTED] had been treating his wife. The Medical Examiner refused to countersign the cause of death put forward by another doctor in [REDACTED]'s practice. This necessitated a post mortem.
5	<u>**CORONER'S CONCERNS**</u> During the course of the investigation 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: – It is <u>**NOT**</u> suggested that any suspicious conduct has taken place. The matter is reported as it is understood to be a cardinal principle that a doctor should not

	treat a close relative. The following documents accompany this report: 1 Post mortem report dated 15th January 2025 2 My letter to dated 14th November 2024
6	**ACTION SHOULD BE TAKEN** In my opinion action should be taken to prevent future deaths and I believe your organisation has 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 19th March 2025. 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 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	Signed: KEVIN McLOUGHLIN Senior Coroner West Yorkshire (E) Date: 22 January 2025