	REPORT TO PREVENT FUTURE DEATHS **REGULATION 28 OF THE CORONERS (INVESTIGATIONS) REGULATIONS 2013**
1.	**CORONER** I am Melanie Sarah Lee, Assistant Coroner, for the coroner area of Inner North London.
2.	**DATE OF REPORT** **17 June 2026**
3.	**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.	**THIS REPORT IS BEING SENT TO** 1. NHS England You are under a duty to respond to this report within 56 days of the date of this report, namely by 12 August 2026. I, the coroner, may extend the period if an appropriate application is made.
4.	**YOUR RESPONSE** 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. I have a duty to send a copy of your response to the Chief Coroner. In accordance with the Chief Coroner's Publication Policy, you should send me any representations regarding publication of your response. These representations should be made at the same time as the response is provided. I will pass any representations received to the Chief Coroner for a decision. Please note any links to webpages included in the response will not be checked for sensitive information prior to publication, as the information is already online. The names of those who do not respond to PFD reports are regularly published on the Chief Coroner's webpages Non-responses to Prevention of Future Death (PFD) reports - Courts and Tribunals Judiciary.

5.	**SUMMARY OF CORONER'S CONCERN** There is no suitable 111 Pathways disposition for pituitary surgery and no prompt for call handlers to ask about hospital discharge advice. See section 9.
6.	**ACTION SHOULD BE TAKEN** In my opinion unless action is taken to address the above concerns then there is a significant risk of future deaths and I believe each of you have the power to take such action.
7.	**INVESTIGATION AND INQUEST** On 6 March 2025, an investigation was commenced into the death of Muluembet ("Mulu") Yohanes, aged 53 years. **The medical cause of death was** 1a. aspiration pneumonitis 1b. ischaemic brain infarction 1c. seizure 1d. hyponatraemia 2. Transsphenoidal surgery for removal of a giant pituitary adenoma on 24/01/2025 **How, when and where** Muluembet Yohanes died on 25 February 2025 in ITU at North Middlesex University Hospital from hypoxic brain injury following a likely seizure and cardiac arrest as a result of hyponatraemia, that in turn being a complication transsphenoidal surgery. **Conclusion** Recognised complication of necessary surgery on a background of a naturally occurring disease process.
8.	**CIRCUMSTANCES OF DEATH** On 24 January 2025 Muluembet Yohanes underwent surgery at the National Hospital for Neurology and Neurosurgery to remove a giant tumour in her pituitary gland. She was discharged on 27 January and she was given red flag advice that concerning symptoms, including vomiting, required immediate medical attention. On 30 January she began suffering with intermittent vomiting.

	When this did not resolve the following day, her son called 111. The outcome of the call was for Mulu to speak to a clinician at a Clinical Assessment Service within 2 hours. A pharmacist called Mulu back and advised home management. During a second call to 111 on 1 February, advice was given that Mulu could attend A&E. Later that morning Mulu suffered a seizure as a result of hyponatraemia, a known complication following transsphenoidal pituitary surgery. On arrival of paramedics she was in cardiac arrest. ROSC was achieved and Mulu was taken to North Middlesex University Hospital where she was found to have a critically low sodium level and an irreversible hypoxic brain injury. She was palliatively extubated and died in ITU on 25 February 2025. Post-operative hyponatraemia after transsphenoidal surgery is a well recognised, potentially life threatening, complication, and severe hyponatraemia carries a high mortality, even with treatment. It is not possible to say whether, had it been identified earlier, Mulu's death would have been avoidable.
9.	**CORONER'S CONCERNS** During the course of the inquest I heard evidence giving rise to concern. In my opinion there is a risk that future deaths could occur unless action is taken. In the circumstances it is my statutory duty to report to you. The **MATTERS OF CONCERN** are as follows: Mulu underwent surgery to remove a giant pituitary tumour on 24 January 2025. She was discharged home on 27 January with hydrocortisone for low cortisol levels. She was given discharge / safety netting / red flag advice, both orally and in writing, which advised her to seek medical help immediately if she vomited more than once. Following discharge, Mulu suffered intermittent vomiting. Her son called the NHS 111 service on 31 January at 16:00 hours. He reported that Mulu had undergone brain surgery and had been vomiting for 48 hours. The outcome of the call was for Mulu to speak to a clinician in a local service within 2 hours. I heard evidence that neurosurgery is not a specified Pathways category, nor is it part of the "vomiting" algorithm. The Call Handler on 31 January 2025 erroneously recorded Mulu's surgery as a "head injury" which resulted in it receiving a higher priority outcome than it otherwise would have done. An ANP called Mulu back at 16:57. They took an account that Mulu had undergone surgery to remove a pituitary tumour a week previously and that she had been vomiting since the previous day, that she vomited when she ate food but that she was drinking well. The disposition reached was "home management", this being that she was to ensure that she remained well hydrated

	and to eat in small amounts. They advised that if she was unable to keep fluids down and had symptoms of dehydration, she would need to be seen in A&E. Again, there was no prompt in relation to brain surgery or for questions about any discharge advice. At 09:37 on 1 February, Mulu's son again called 111 reporting that she had deteriorated. As he was not with Mulu, no assessment was conducted but advice was given repeatedly that Mulu could attend hospital or contact 111 directly if she remained unwell. At 11:21 on 1 February 2025 Mulu was found unresponsive and an ambulance was called. Paramedics arrived at 11:40 and found Mulu in cardiac arrest. It is likely that Mulu suffered a seizure, followed by cardiac arrest, due to hyponatraemia. Neither the 111 nor Clinical Assessment Service asked Mulu whether the hospital had given her any post-surgical discharge, worsening or red flag worsening advice. Had they done so, this may have prompted Mulu to review the written discharge advice she had been given. That advice was that vomiting was a safety alert; that repeated vomiting required immediate medical help; that any concerning symptoms required medical attention from a GP, A&E or UCLH directly and that for persistent vomiting, advice on hydrocortisone should be sought from 111, 999 or A&E. 1. LAS informed me that they have advised Pathways of Mulu's case and recommended that Neurosurgery be added to the supporting information for "head injury" and "vomiting" algorithms. I do not know if Pathways have, or have agreed to, action this or what the timescales are. 2. I am concerned that without a dedicated pathway for "neurosurgery", it is left to call handlers to choose the most appropriate pathway. To me, "head injury" is not reflective of elective, non-trauma surgery. 3. Pathways does not include a question for post-discharge surgery patients about whether they have been given discharge, worsening or red flag advice by their surgical team.
10.	**COPIES AND PUBLICATION OF THIS REPORT** I have a duty to send a copy of my report to every Interested Person who in my opinion should receive it. I also may send a copy of the report to any other person who I believe may find it useful or of interest.

	I can confirm I have sent the report to: 1. Mulu's family 2. University College London Hospitals NHS FT 3. Royal Free London NHS FT 4. London Ambulance Service NHS FT 5. London Central & West Unscheduled Care Collaborative I also have a duty to send a copy of the report to the Chief Coroner. You may make representations to me, the coroner, about the publication of the contents of this report in line with Chief Coroner's PFD Publication Policy (2026). Any representations will be sent to the Chief Coroner alongside the report. Please refer to box 4 above for additional information relating to the publication of reports and responses.
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