Her Majesty's Coroner for the
Northern District of Greater London
(Harrow, Brent, Barnet, Haringey and Enfield)

North London Coroners Court,
29 Wood Street,
Barnet EN5 4BE

Telephone 0208 447 7680
Fax 0208 447 7689

	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO:** Department of Health Richmond House 79 Whitehall London SW1A 2NS
1	**CORONER** I am Andrew Walker, senior coroner, for the coroner area of Northern District of Greater London
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 the 9th June 2014 I opened an investigation touching the death of Hana Aisha Abd Elhamid , 25 years old. The inquest concluded on the 7th May 2015. The conclusion of the inquest was "Narrative", the medical case of death was 1a Respiratory failure 1b Tracheal Stenosis complicating laryngotracheal injury sustained during self-extubation during treatment for a diabetic coma
4	**CIRCUMSTANCES OF THE DEATH** Miss Abd Elhamid was a patient being treated for a mental health condition and it became necessary to treat her condition with Clozapine. It is likely that the diabetes was a complication of the use of Clozapine and routine fasting blood tests were not carried out which was a serious failure. It is likely that the diabetes had been developing for some time before Miss Abd Elhamid became seriously unwell whilst on a home visit. Miss Abd Elhamid was taken to the hospital on the 13th November 2012. There was a medical need to intubate Miss Abd Elhamid and during the process of waking Miss Abd Elhamid extubated herself. Although this is not unusual in these circumstances in this case the result was damage to the airway. Many attempts were made to treat Miss Abd Elhamid at a specialist hospital where a tracheal stent was fitted. Miss Abd Elhamid became unwell with breathing difficulties and was admitted to hospital on the 4th June 2014. A decision was taken to attempt to treat Miss

	Abd Elhamid which encountered such difficulties due to the narrowed airway that Miss Abd Elhamid died. There was an opportunity to test for blood sugar which is likely to have demonstrated the presence of diabetes at a time where the diabetes would have been amenable to treatment. There was therefore an opportunity to render care which if taken would have prevented the death.
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. – that this patient developed diabetes whilst on long term Clozapine treatment and that routine blood tests for sugar in the blood are likely to have prevented events, the need for intubation during treatment for a diabetic coma with resultant trachea injury following self -extubation, that directly led to the patients death
6	**ACTION SHOULD BE TAKEN** In my opinion action should be taken to prevent future deaths and I believe you [AND/OR your organisation] 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 Wednesday 8th July 2015. 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;- Representatives of [redacted] Glen Care [redacted] Royal Free London NHS Foundation Trust Barnet Hospital. Barnet Enfield and Haringey Mental Health Trust. 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	**13th May 2015**