REGULATION 28: REPORT TO PREVENT FUTURE DEATHS (1)

	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO:** 1. Dr [redacted] & Partners, Croft Shifa Health Centre, Belfield Road, ROCHDALE
1	**CORONER** I am Catherine McKenna, Area 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 1 June 2021 an investigation into the death of Sameena Javed was commenced. The investigation concluded at the end of the inquest on 20 December 2021. The conclusion was Natural Causes
4	**CIRCUMSTANCES OF DEATH** Sameena Javed was 33 years old when she presented at the Royal Oldham Hospital on 27 May 2021. She had severe complications of anorexia nervosa, malnutrition and heart failure. She was found to have COVID 19 pneumonitis and was transferred to the Intensive Care Unit. Despite treatment, Mrs Javed deteriorated and died on 30 May 2021. The medical cause of death was 1a) multi organ failure 1b) Covid 19 pneumonitis 2) Dilated cardiomyopathy, severe malnutrition, chronic pancreatitis and chronic hepatitis B. Mrs Javed's very low level of physiological reserve was a contributory factor in her death. Mrs Javed had been referred to the community Eating Disorder Service (EDS) by a Liaison Consultant Psychiatrist in February 2020 who had assessed her when she was an inpatient on the labour ward following a still-birth. The EDS made a number of attempts to contact Mrs Javed but in April 2020 discharged her when she failed to respond to correspondence. On 9 April 2020, the EDS sent a letter to the GP practice in which it discharged Mrs Javed back to the care of the GP and recommended ongoing medical monitoring. The Court heard evidence that the discharge letter from EDS was filed by administrative staff at the surgery without being seen by a GP and that had it been seen, the GP would have requested blood tests and kept 'an eye' on Mrs Javed's weight, eating habits and nutrition. Whilst it was not possible to say, on the available evidence, whether Mrs Javed would have engaged with any efforts by the GP practice to monitor her weight and eating habits, it was an opportunity to provide care and foster engagement with health services that was missed. The Court heard of a further incident when relevant paperwork sent to the surgery was not placed before a GP. An Out of Hours doctor had been called to see Mrs Javed at her home address on 6 May 2021. However, when the Out of Hours doctor arrived, Mrs Javed had inexplicably denied him access to her home. The Out of Hours doctor sent an email to the GP practice detailing the circumstances of the aborted visit. This email was not placed before a GP and the Court heard that had it been, it would have resulted in the GP making telephone contact with Mrs Javed to inquire into her health and the reason why she had declined the visit.

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) The Court heard that incoming correspondence to the GP practice is dealt with by administrative staff who are responsible for deciding whether it should be placed before a GP. There is no written procedure or guidance in place at the GP Practice which guides administrative staff on which correspondence needs to be placed before the GP before it is filed within the patient records. The concern is that there is no system in place to ensure that communication to the surgery which requires actions to be taken by the medical staff is brought to their attention.
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 **21 February 2022**. I, the Area 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:- • The family of the Deceased • Pennine Care NHS Foundation 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 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.
-	Date: 23 December 2021 Signed: