## REGULATION 28: REPORT TO PREVENT FUTURE DEATHS (1)

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| | **REGULATION 28 REPORT TO PREVENT FUTURE DEATHS**<br><br>**THIS REPORT IS BEING SENT TO:**<br><br>**1. NHS England**<br>**2. Castlefields Health Centre** |
| 1 | **CORONER**<br><br>I am Nicholas Leslie Rheinberg, senior coroner for the coroner area of Cheshire |
| 2 | **CORONER'S LEGAL POWERS**<br><br>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**<br><br>On 10th August 2012 I commenced an investigation into the death of Carol Ann Gibson aged 65. The investigation concluded at the end of the inquest on 8th August 2013. The conclusion of the inquest was that the deceased died as a result of an adverse reaction to the drug nitrofurantoin and that her death was due to misadventure. |
| 4 | **CIRCUMSTANCES OF THE DEATH**<br><br>The deceased had a history of severe urinary tract infections with severe symptoms of both a physical and mental nature. In 2007 her General Practitioner [redacted] having taken advice from a consultant prescribed the drug nitrofurantoin on a prophylactic basis. The deceased subsequently suffered from serious lung disease as an adverse reaction to the drug and when in 2008 this was recognised as a probability, the prescription of the drug was discontinued and an alert was subsequently posted in the patient's medical records. In 2011 the deceased again suffered a urinary tract infection. [redacted] failed to heed the alert within the medical records and on 10th August 2011 issued a prescription for nitrofurantoin. [redacted] issued a further prescription for the drug on 12th April 2012 and on 26th July 2012 a nurse practitioner within the medical practice also issued a prescription for the drug. On 1st August 2012, without examining the patient, a final prescription of nitrofurantoin was issued. On 8th August 2012 the deceased died at her home at [redacted] Palacefields, Runcorn as a result of an adverse reaction to nitrofurantoin. |
| 5 | **<u>CORONER'S CONCERNS</u>**<br><br>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.<br><br>The **MATTERS OF CONCERN** are as follows.<br><br>1. [redacted] ignored a warning alert in the medical records that his patient had suffered an adverse reaction to nitrofurantoin without checking the nature of the adverse reaction and issued a prescription for the drug regardless.<br>2. A letter dated 3rd November 2008 was sent by a consultant to [redacted] at Castlefields Health Centre identifying that the interstitial lung disease from which |

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| | 3. [redacted] on commenting on alert warnings, said that most are "trivial, spurious, irrelevant or just wrong", identified a phenomenon that he described as alert fatigue and further stated that colleagues within the practice had admitted that they "may well have done the same in my situation".<br><br>I am concerned that if [redacted] comments correctly describe the attitude within his medical practice to patient safety alerts this is a matter of considerable concern and warrants investigation by you to ensure first of all that the practice has a robust system in place for posting such alerts, secondly that such alerts when posted, correctly and sufficiently identify the problem and thirdly that doctors and medical staff within the practice have full understanding and training to respond to such alerts in an appropriate manner. |
| 6 | **ACTION SHOULD BE TAKEN**<br><br>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**<br><br>You are under a duty to respond to this report within 56 days of the date of this report, namely by 7th October 2013. I, the coroner, may extend the period.<br><br>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**<br><br>I have sent a copy of my report to the Chief Coroner and to the following Interested Persons namely the solicitors representing [redacted] the deceased's daughter and the solicitors representing [redacted]<br><br>I am also under a duty to send the Chief Coroner a copy of your response.<br><br>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 | **12th October 2013]** |