REGULATION 28: REPORT TO PREVENT FUTURE DEATHS (1)

*NOTE: This form is to be used **after** an inquest.*

	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO:** **1.** Clinical Director, Royal Bolton Hospital, Minerva Road, Farnworth, Bolton.
1	**CORONER** I am Timothy W Brennand, HM Assistant Coroner for the Coroner Area of Manchester West.
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 1st June 2017 I commenced an investigation into the death of Carol Buchanan, aged 65. The investigation concluded at the end of the inquest on the 6th October 2017. The medical cause of death was:- Ia Coronary Artery Thrombosis Ib Ischaemic Heart Disease II Urosepsis and Rhabdomyolysis (clinical) My conclusion as to the death was "Misadventure".
4	**CIRCUMSTANCES OF THE DEATH** The deceased had a history of previous stroke, morbid obesity, chronic obstructive pulmonary disease, cerebral vascular disease and asthma. As part of the ongoing treatment and care in the community the deceased had been prescribed Simvastatin therapy by her general practitioner. On the 27th April 2017, the deceased was prescribed a trial prescription of Itraconazole anti-fungal medication to treat diagnosed Aspergillus sensitization following analysis of results from recent blood tests at a respiratory outpatient service. The Simvastatin prescription appeared on a "GP Care Summary Record" but this information was not available at the outpatient clinic. Furthermore, there were no records at all of the Itraconazole prescription by reason of a delay in typing a clinic letter. On the 18th May 2017 the deceased was admitted as an inpatient at the Royal Bolton Hospital, Minerva Road, Farnworth, Bolton presenting with symptoms ultimately diagnosed as acute kidney injury with high potassium due

	to urine infection with dehydration. Her condition was managed conservatively and between 18th May 2017 and 21st May 2017 there were accepted missed opportunities to consider family concerns and information as to the deceased's recent history of prescriptions and fluid imbalance as being causative or contributory to her deterioration. The combined prescription of Simvastatin and Itraconazole caused a rare but recognised complication in the form of a cross reaction leading to Rhabdomyolysis and muscle necrosis. The deterioration in her condition was recognised but its significance not appreciated until the 24th May 2017 when the consequences of the cross reaction of prescriptions was diagnosed upon the deceased being admitted to the intensive care unit. Despite active treatment and management thereafter, the condition of the deceased further deteriorated and on the 26th May 2017 she died.
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 prescription of Itraconazole was undertaken at the Royal Bolton Hospital's Respiratory Outpatient Clinic without the consultation or cross referencing of the information contained in the "GP Summary Care" documentation; 2. In the absence of access to such documentation, clinicians are instructed to make use of information provided verbally by the patient/family or carer, which in the event of a patient presenting with complex co-morbidities requiring an extensive prescription regime can give rise to incomplete or inaccurate relevant prescription history; 3. The prescription of Itraconazole on the 27th April 2017 was not typed up into relevant records – either by way of the "GP clinic letter" or elsewhere in a timely or effective manner; 4. The very rare but serious drug interaction between Itraconazole and Simvastatin which contributed to the cause of death was not appreciated; 5. In the Divisional review undertaken by the Bolton NHS Foundation Trust it was noted that the correct diagnosis was assisted "with further information from the family" notwithstanding that in fact, between admission on the 18th May 2017 and the 21st May 2017 the family had made repeated representations and provided specific information in circumstances that demonstrate:- a. The concerns and representations were not noted adequately; b. The importance of the history was not appreciated or acted upon; c. Missed opportunities arose between the 18th and 21st May 2017 to act on concerns relating to dehydration and urine output and a consequent delay in implementation of fluid balance monitoring; d. The delay in specific diagnosis of the underlying cause of the patients presenting symptoms;
6	**ACTION SHOULD BE TAKEN** In my opinion urgent action should be taken to prevent future deaths and I believe that you 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 November 18th 2017. 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:- 1. [redacted] 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	**Dated** **12th October 2017**	**Signed** **Timothy W Brennand, HM Assistant Coroner**