# Re : CHAND ALI DECEASED

# REGULATION 28 REPORT TO PREVENT FUTURE DEATHS

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| | **REGULATION 28 REPORT TO PREVENT FUTURE DEATHS**<br><br>**THIS REPORT IS BEING SENT TO:**<br><br>**1. The Director of Barts Heart Centre, St. Bartholomew's Hospital** |
| 1 | **CORONER**<br><br>I am Alison Hewitt, HM Senior Coroner for the City of London. |
| 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>I commenced an investigation into the death of Chand Ali on 14th December 2017. The investigation concluded at the end of the inquest on 28th February 2019. |
| 4 | **CIRCUMSTANCES OF THE DEATH**<br><br>The Deceased was a 78 year old man who suffered severe, end-stage, heart failure and was diabetic. On the 7th July 2017 he attended the outpatient heart failure clinic at St Bartholomew's Hospital for review and was found to have developed significant fluid overload and decompensated heart failure and, in consequence, at about 3pm he was admitted to Ward 6D of the hospital. Upon admission and over the following hours the Deceased was alert and responsive. At about 5.20 pm he was given an intra-venous dose of cyclizine, an antiemetic which, according to the British National Formula, must be used with caution for patients suffering severe heart failure. At about 6.45 pm he was found to have a low blood glucose level and this was treated with the provision juice and food, which he drank and ate, and the administration of glucogel. Subsequently, at about 7.20 pm, he was found to be unresponsive and his death was pronounced at 7.50 pm. On the balance of probabilities the Deceased's death resulted from his decompensated heart failure. The possibility that the dose of cyclizine contributed to the heart failure and death cannot be ruled out but, on the evidence available, could not be said to be probable. |

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| | The medical cause of death was :<br><br>Ia Decompensated Heart Failure<br>Ib Ischaemic Heart Disease<br>II Chronic Renal Failure, Diabetes<br><br>My conclusion as to the death was : Natural Causes |
| 5 | **CORONER'S CONCERNS**<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 as a result 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>As stated above, cyclizine is an antiemetic which, according to the British National Formula, must be used with caution for patients suffering severe heart failure, especially if it is administered intra-venously.<br><br>The evidence revealed that cyclizine is administered to heart failure patients at St. Bartholomew's Hospital, including those suffering severe heart failure, as the routine or standard antiemetic and without consideration of its likely effect on the individual patient in question. There is no system in place in the hospital requiring the prescriber to balance any risk to the patient arising from the use of cyclizine against the patient's clinical need for it, in order to justify its prescription.<br><br>Further, whilst it was said that the Hospital was not aware of any pattern or trend of deaths following the administration of cyclizine, it was accepted that the actual incidence of such deaths was not, in fact, known. It was accepted that monitoring and analysis of all deaths following the recent use of cyclizine would be needed in order to establish a reliable picture.<br><br>It was also apparent from the evidence that there had been no comprehensive review of other available antiemetics in order to explore whether there exists and effective alternative antiemetic which is not subject to a caution in the British National Formula as to its use. |
| 6 | **ACTION SHOULD BE TAKEN** |

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| | In my opinion action should be taken to prevent future deaths by addressing the concerns set out above 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 **2nd May 2019**. 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, to the following Interested Persons and to the other organisations listed below which may find it useful or of interest.<br><br>[redacted] (Son of the Deceased)<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 | **7th March 2019** **Alison Hewitt** |