**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: Park View Group Practice, Chief Executive of Stockport Clinical Commissioning Group (CCG), Chief Officer of Greater Manchester Health and Social Care Partnership |
| 1 | CORONER<br><br>I am Alison Mutch, Senior Coroner, for the Coroner Area of Greater Manchester South |
| 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 20th February 2019 I commenced an investigation into the death of Graham Earl. The investigation concluded on the 14th August 2019 and the conclusion was one of **Narrative: Died from influenza exacerbated by the complications of prescribed medication, namely Amiodarone.** The medical cause of death was **1a) Influenza Pneumonia on a background of Pulmonary Fibrosis caused by Amiodarone therapy; II) Diabetes Mellitus (Type 2), Ischaemic Heart Disease, Atrial Fibrillation** |

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| 4 | CIRCUMSTANCES OF THE DEATH<br><br>Graham Earl had a history of Atrial Fibrillation. A Cardioversion on 2nd May 2018 successfully restored his heart rhythm. Amiodarone was prescribed to maintain his rhythm. On 2nd January 2019 he was diagnosed via a chest x-ray with Pulmonary Fibrosis, a known complication of Amiodarone therapy. He was not referred back to the cardiologist. Had he been referred back, the Amiodarone would have been stopped. He continued to deteriorate. On 14th February 2019 he was acutely unwell and was admitted to Stepping Hill Hospital. He was diagnosed with influenza. His Pulmonary Fibrosis exacerbated the impact of the influenza. He deteriorated and died at Stepping Hill Hospital on 16th February 2019. |
| 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 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. The GPs involved did not understand or recognise the known link between the therapy and Pulmonary Fibrosis and did not seek guidance from the prescribing secondary care physician at an early stage. The evidence was that the advice would have been to stop prescribing immediately;<br><br>2. A GP amended the prescription subsequently without reference to the secondary care doctor despite the fact that this is not a medication started in primary care;<br><br>3. The indication was that GPs involved were not aware of what they should do if there were side effects from the medication in terms of escalation;<br><br>4. The drug is currently green on the CCG classification. In other CCG areas it is amber given the known side effects. |
| 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. |

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| 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 25th November 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 and to the following Interested Persons namely; [redacted] on behalf of the family, who may find it useful or of interest.<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 | **Alison Mutch OBE**<br>**HM Senior Coroner**<br>**30.09.2019** |