Regulation 28: REPORT TO PREVENT FUTURE DEATHS

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

	REGULATION 28 REPORT TO PREVENT DEATHS **THIS REPORT IS BEING SENT TO:** **1 NHS England & NHS Improvement (PFDs)**
1	**CORONER** I am Anita BHARDWAJ, Area Coroner for the coroner area of Liverpool and Wirral
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 06 February 2023 I commenced an investigation into the death of Amirah KHALIFA aged 42. The investigation concluded at the end of the inquest on 24 November 2023. The conclusion of the inquest was that: Narrative Conclusion: Inappropriate and prolonged administration of steroids contributed to by neglect.
4	**CIRCUMSTANCES OF THE DEATH** Amirah Khalifa was a 41 year old lady who had a complex medical history, including a presumed hepatocellular carcinoma for which she underwent a TACE (trans arterial chemoembolization) in 2016. On 31 August 2018 Amirah was admitted to the Royal Liverpool Hospital presenting with vomiting and right upper quadrant pain, a known complication after a TACE procedure. Various medications were prescribed but the pain was ongoing. On 11 September 2018, whilst still in hospital, Amirah was prescribed dexamethasone (a steroid), initially [redacted] twice daily and then [redacted] once a day. She was then discharged from hospital. A discharge summary was sent to her General Practice (GP) requesting the steroid medication to be reviewed. When the steroids were prescribed there was no indication noted as to the length of the intended treatment course in the clinical notes or in the discharge letter issued by the hospital team. In April 2019 the steroids were noted as a repeat prescription in the GP records rather than an acute prescription. It is unclear upon what basis this was done. On 12 June 2019 Amirah was admitted to the Royal Liverpool University Hospital with dizzy spells. It was noted that her high blood pressure was poorly controlled. Her dexamethasone was continued in hospital and on discharge. A discharge summary was sent to her GP practice with the steroids to be continued. On 12 September 2019 Amirah was admitted to the Royal Liverpool hospital with similar symptoms. Her dexamethasone was continued again in hospital and on discharge. Throughout 2019-2022 Amirah had numerous consultations with various specialists in the Royal Liverpool University Hospital. On 29 December 2022 Amirah was admitted to the Royal Liverpool University Hospital feeling generally unwell and with leg pain. Treating medical professionals deemed that Amirah's case was complex and multiple organ systems were investigated and treated. Despite active treatment Amirah deteriorated and died on 31 January 2023. The post mortem examination found it was more likely than not Amirah died as a result of multiple organ failure caused by sepsis and intestinal haemorrhage as a result of long term steroid therapy. Throughout, on each discharge from hospital, a discharge letter was sent to Amirah's GP and was generally to continue the

	dexamethasone. There were a number of failures relating to the care and treatment afforded to Amirah; through numerous appointments an incomplete medication history was taken and documented which did not include dexamethasone. Amirah had multiple complex conditions and was under the care of numerous specialists, many of whom clearly did not appreciate she was on steroids, and had been, for a lengthy period of time. Amirah was seen by numerous clinicians both in the hospital and in the community and at no stage was it questioned as to why she was still on the steroids, and why at the high dose she was on. Evidence has been heard that it was rare for a patient to be on these steroids at this dose for a lengthy period of time. Amirah presented with symptoms clearly suggestive of the possibility of complications of steroid use, namely uncontrollable blood pressure, diabetes, swelling and cognitive impairment. There was a failure to recognise these obvious presentations and the link between them and the long term steroid use. There was a failure to document in the clinical notes and / or in the discharge letter, the indication or length of the dexamethasone tablets. This failure prevented adequate instructions being provided to Amirah's GP as to the intended length of the dexamethasone treatment and monitoring of the same. There was a failure for the GP to clarify the discharge with the hospital and to review the medication, this failure was exacerbated by the fact the prescription was changed to repeat from acute with no apparent reason. Overall, there was a catalogue of missed opportunities both in hospital as well as in the community to identify that Amirah remained unnecessarily on dexamethasone tablets despite multiple reviews as an inpatient and outpatient. Even when the ongoing prescription was identified, and Amirah was symptomatic of Cushing's disease and steroid induced diabetes the correct action to wean treatment completely was not undertaken. It is a basic and fundamental expectation for a clinician in charge of a patient's care to monitor and review prescribed medication, particularly acute medication such as steroids. There was a failure to do this for Amirah despite the fact that there were numerous opportunities to do so over a lengthy period of time. The accumulation of failures through the primary and secondary care services has led to a gross failure to provide basic medical attention to Amirah who was in a dependent position and had every reason to rely upon those who had management of her care and treatment to prescribe, monitor and review her medication. It is more likely than not the inappropriate and prolonged administration of steroids caused Amirah's death.
5	**CORONER'S CONCERNS** During the course of the investigation my inquiries revealed matters giving rise to concern. In my opinion there is a risk that future deaths could occur unless action is taken. In the circumstances it is my statutory duty to report to you. The **MATTERS OF CONCERN** are as follows: (brief summary of matters of concern) 1. The current SCR model does not appear to automatically flag drugs such as steroids, which are known to have potentially fatal side effects if used for the long term without appropriate monitoring. It is understood that some drugs do have these flags, but that steroids do not. 2. In addition, the SCR does not have a space recording for clinical indication for initiation of the drugs, to aid a future prescriber to consider whether the drug is still clinically indicated.
6	**ACTION SHOULD BE TAKEN** In my opinion action should be taken to prevent future deaths and I believe you (and/or your organisation) 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 January 22, 2024. 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 [redacted] **Royal Liverpool University Hospital** **Sandringham Medical Centre** I have also sent it to who may find it useful or of interest. I am also under a duty to send a copy of your response to the Chief Coroner and all interested persons who in my opinion should receive it. I may also send a copy of your response to any person who I believe may find it useful or of interest. 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: 27/11/2023**  **Anita BHARDWAJ** **Area Coroner for** **Liverpool and Wirral**