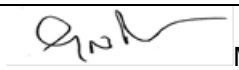
MISS N PERSAUD
HER MAJESTY'S CORONER
EAST LONDON
Walthamstow Coroner's Court, Queens Road Walthamstow, E17 8QP
[redacted]

REGULATION 28: REPORT TO PREVENT FUTURE DEATHS (1)

Ref:111016

	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO:** • [redacted], **Executive Director, Academy of Medical Royal Colleges (AOMRC)** [redacted]
1	**CORONER** I am Nadia Persaud area coroner for the coroner area of East London
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. http://www.legislation.gov.uk/ukpga/2009/25/schedule/5/paragraph/7 http://www.legislation.gov.uk/uksi/2013/1629/part/7/made
3	**INVESTIGATION and INQUEST** On 28/09/2019 I commenced an investigation into the death of Gary David Ash (aged 62 years). The investigation concluded at the end of the inquest on the 22nd April 2024. The conclusion of the inquest was a narrative conclusion: *Mr Ash's death was contributed to by an adverse drug reaction following a general anaesthetic that he was not correctly consented for, and by an over administration of fluid whilst in the critical care department.*
4	**CIRCUMSTANCES OF THE DEATH** Mr. Gary Ash suffered from long standing ulcerative colitis. In May 2019 he was referred to the two-week-wait surgical clinic, for anaemia and rectal bleeding. He was seen by a

	surgeon on 31 May 2019 who advised Mr. Ash that the necessary investigations could be carried out under a general anaesthetic. The Trust policy on seeking consent for a general anaesthetic was not followed. On the balance of probability, had Mr. Ash been carefully consented by an anaesthetist, he would have accepted deep sedation as an effective and safer form of anaesthesia. On the 24 June 2019, Mr. Ash underwent the necessary investigations and, in the absence of a valid consent, received a general anaesthetic. Very shortly after the procedure, he developed signs and symptoms of serotonin syndrome. Serotonin syndrome was not recognised by the treating clinicians and the diagnosis has now been made with the benefit of hindsight and the benefit of expert opinion. The primary differential diagnosis of neuroleptic malignant syndrome was made on 24 June 2019. Mr Ash was admitted to critical care on the evening of 24 June 2019. Due to excessive sweating, Mr. Ash was prescribed a large amount of intravenous fluids. These fluids were not carefully monitored and reviewed. The fluids were not reduced when the sweating decreased and the urine output was noted to be low. Additional boluses of fluids were administered by nursing staff, with no clear rationale. By 1230pm on the 25 June 2019, Mr. Ash had a positive fluid balance of 4.9L. This was recorded, but not acted upon as a red flag. The oxygen level in Mr Ash's blood was decreasing and need for oxygen increasing on the morning of 25 June 2019. Dantrolene was administered to him as an intravenous infusion. This involved additional fluid administration and during the course of the Dantrolene infusion, Mr Ash suffered a cardiac arrest. It is likely that the cardiac arrest was caused by pulmonary oedema and resultant hypoxaemia. Mr. Ash passed away at Queen's Hospital on the 25 June 2019.
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 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: The Inquest heard evidence from an expert (Professor of Anaesthesia), who has a specialist expertise in adverse drug reactions following anaesthesia and specialist expertise in the conditions of neuroleptic malignant syndrome and malignant hyperthermia. The Professor raised concern, which was reflected in the inquest evidence, in relation to general medical knowledge relating to the following: 1. Management of the condition neuroleptic malignant syndrome, including the inappropriate, off licence, use of Dantrolene. 2. The role of Dantrolene in the development of pulmonary oedema in the presence of intravenous fluid overload. 3. The potential interaction between Dantrolene and Labetalol in relation to the reduction of cardiac contractility. 4. The lack of knowledge around the diagnosis of serotonin syndrome and the risk of it developing following the combined use of Fentanyl and Ondansetron as part of anaesthesia.
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 **24 June 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 family of Gary David Ash, the Care Quality Commission, Barking, Havering and Redbridge University Hospitals Trust, MHRA and the local Director of Public Health 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 other 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.
q	**29 April 2024**  Ms G N Persaud