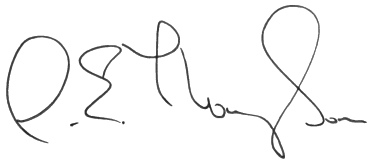
Regulation 28: REPORT TO PREVENT FUTURE DEATHS

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

	REGULATION 28 REPORT TO PREVENT DEATHS **THIS REPORT IS BEING SENT TO:** **1 Chief Executive - County Durham & Darlington NHS Foundation Trust**
1	**CORONER** I am James E THOMPSON, Assistant Coroner for the coroner area of County Durham and Darlington
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 15/03/2023 09:42an investigation was commenced into the death of Gillian PEACOCK 16/08/1962 00:00:00. The investigation concluded at the end of the inquest on 05/06/2024 00:00. The conclusion of the inquest was that Gillian Peacock died on 8th March 2023 at Darlington Memorial Hospital. She suffered from a number of health conditions, but significantly atrial fibrillation for which she was prescribed digoxin. She was admitted to hospital on 27th February 2023 and was diagnosed with a chest infection and was prescribed clarithomycin. It was recorded by a hospital pharmacist on 1st March 2023 in her medical notes that the use of these two drugs can cause digoxin toxicity and an alternative drug or monitoring is advised. No alternative drug was prescribed and no monitoring took place until 7th March 2023 where results showed an elevated level of digoxin. Her digoxin was withheld. She had displayed no recognised symptoms of digoxin toxicity during her stay in hospital. She suffered a cardiac arrest on the morning of 8th March 2023 and died. Post Mortem examination could not ascertain a cause of death. The medical evidence cannot on the balance of probabilities determine the contribution of digoxin & clarithomycin to her death..
4	**CIRCUMSTANCES OF THE DEATH** Gillian Peacock died on 8th March 2023 at Darlington Memorial Hospital. She suffered from a number of health conditions, but significantly atrial fibrillation for which she was prescribed digoxin. She was admitted to hospital on 27th February 2023 and was diagnosed with a chest infection and was prescribed clarithomycin. It was recorded by a hospital pharmacist on 1st March 2023 in her medical notes that the use of these two drugs can cause digoxin toxicity and an alternative drug or monitoring is advised. No alternative drug was prescribed and no monitoring took place until 7th March 2023 where results showed an elevated level of digoxin. Her digoxin was withheld. She had displayed no recognised symptoms of digoxin toxicity during her stay in hospital. She suffered a cardiac arrest on the morning of 8th March 2023 and died. Post Mortem examination could not ascertain a cause of death. The medical evidence cannot on the balance of probabilities determine the contribution of digoxin & clarithomycin to her 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) Gillian Peacock was admitted to hospital on 27th February 2023 and was diagnosed with a chest infection and was prescribed clarithomycin. It was recorded by a hospital pharmacist on 1st March 2023 in her medical notes that the use of these two drugs can cause digoxin toxicity and an alternative drug or monitoring is advised. No alternative drug was prescribed and no monitoring took place until 7th March 2023. The evidence I have heard is that the treating clinicians had not seen the entry in her medical records. This was in part due to the way the entries are displayed in the records and the 'huge' number of entries that are recorded. I heard that now that any pharmacist entries of significance must be verbally passed to a junior doctor involved in the patient's care and in turn passed on at ward meetings to the broader group of staff caring for that patient. I have a concern that the current system does not address the issue of important medical information being recorded in a patient's notes not being accessible in such a way that clinicians can see and if necessary act on it. The use of verbal handovers does not in my view fully address my concern that crucial medical information should be recorded in a patient's medical records in such a way that relevant information is visible to those involved in care. In addition, that it can be accessed immediately without reliance on the verbal passing of information from one member of the treating team to another.
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 July 31, 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] I have also sent it to **Care Quality Commission** 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: 05/06/2024**  **James E THOMPSON** **Assistant Coroner for** **County Durham and Darlington**