REGULATION 28: REPORT TO PREVENT FUTURE DEATHS (1)

	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO:** **1. National Institute for Health and Care Excellence and the British National Formulary, 3rd floor,3 Piccadilly Place, Manchester, M1 3BN** **2. London office Royal College of Physicians 11 St Andrews Place Regent's Park London NW1 4LE**
1	**CORONER** I am Nicholas Walker, Area Coroner, for the coroner area of Hampshire, Portsmouth and Southampton.
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 19th September 2023 an investigation was commenced into the death of Chloe Elizabeth Burgess. The investigation concluded at the end of the inquest on 12th February 2025. The conclusion of the inquest was that the effect of medication in combination contributed to Chloe's death.
4	**CIRCUMSTANCES OF THE DEATH** Chloe Elizabeth Burgess was found deceased at home at [redacted] Southampton, Hampshire on 8th September 2023. Chloe was prescribed heart medication after a diagnosis of sinus tachycardia and left bundle branch block as well as antidepressant medication. It is likely that the medication interacted with each other to raise the levels of amitriptyline in Chloe's blood which, combined with her heart medication and an episode of sleep apnoea, induced severe cardiac arrhythmia and sudden cardiac death. She had been using the combination of drugs for four years before she died without concern. The potential dangers of the combination of drugs in Chloe's case was not well-known or appreciated by those treating her. .

5	**CORONER'S CONCERNS** During 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 that the potential dangers of the combination of amitriptyline, paroxetine and ivabradine is not widely appreciated and does not trigger an alert on the prescribing software used in primary care or by pharmacists. The potential dangers related to a failure to metabolise amitriptyline which can, incrementally, lead to toxicity. I am also concerned that those prescribing ivabradine should have a full understanding of the potential interaction with amitriptyline and paroxetine.
6	**ACTION SHOULD BE TAKEN** In my opinion action should be taken to prevent future deaths and I believe 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 28th April 2025 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: The family of Chloe Burgess I am also under a duty to send the Chief Coroner a copy of your response. 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	**Signed by the Coroner** **4th March 2025**