IN THE SURREY CORONER'S COURT IN THE MATTER OF:

The Inquest Touching the Death of Venetia Clarissa Pierce A Regulation 28 Report – Action to Prevent Future Deaths

1 THIS REPORT IS BEING SENT TO:

Chief Executive

Medicines and Healthcare Products Regulatory Agency (MHRA)

Chief Executive

EMIS Health

2 CORONER

Ms Susan Ridge, H.M. Assistant Coroner for Surrey

3 | CORONER'S LEGAL POWERS

I make this report under paragraph 7(1) of Schedule 5 to The Coroners and Justice Act 2009.

4 INQUEST

An inquest into Mrs Pierces death was opened on 16 January 2025. The inquest was resumed and concluded on 6 August 2025.

The medical cause of Mrs Pierces' death was:

- 1a. Nitrofurantoin induced pneumonitis
- 2. Frailty

With respect to where, when and how Mrs Pierce came by her death it was recorded at Box 3 of the Record of Inquest as follows:

Venetia Clarissa Pierce died at the Royal Surrey County Hospital, Guildford on 30 December 2024 from nitrofurantoin induced pneumonitis a recognised complication of taking that antibiotic. Her underlying frailty contributed to the cause of death as it undermined her ability to recover. Mrs Pierce had been prescribed nitrofurantoin in February 2024 as prophylactic treatment to prevent recurrent urinary infections.

The inquest concluded with a narrative conclusion:

Recognised complications of nitrofurantoin medication.

5 | CIRCUMSTANCES OF THE DEATH

During the course of the inquest the court heard that Mrs Pierce, an elderly frail lady suffered with recurrent urinary infections. In February 2024 she was prescribed nitrofuration by her surgery as a prophylactic treatment to prevent those infections. As this helped Mrs Pierce, the prescription was placed on repeat and she continued to take the antibiotic as a prophylactic. Over 2024, Mrs Pierce reported a number of lower respiratory tract infections and periods of coughing. On 22 December 2024 she was taken to hospital and admitted with symptoms of a chest infection. Although her infection appeared to have reduced and she was actively treated with antibiotics and steroids, Mrs Pierce continued to decline. Further testing and examination of her history revealed that it was more likely than not that she had developed nitrofurantoin induced pneumonitis which led to her death on 30 December 2024.

6 | CORONER'S CONCERNS

The **MATTERS OF CONCERN** are:

- a. The MHRA issued a drug safety alert regarding the risks of pulmonary and hepatic adverse drug reactions in relation to nitrofurantoin in April 2023. However, no MHRA safety alert appeared on the surgery EMIS system when the drug was prescribed to Mrs Pierce. The court heard that the safety alert only arises when patients have a pre-existing pulmonary disease which Mrs Pierce did not have.
- b. Although a "recognised" complication, understanding of the potential for pulmonary damage and respiratory failure from use of nitrofurantoin in the elderly may remain low. The court heard evidence from a respiratory consultant that awareness amongst GPs, hospital clinicians including urologists was limited and that even if Mrs Pierce had been referred to hospital earlier the condition might not have been diagnosed.

7 ACTION SHOULD BE TAKEN

In my opinion action should be taken to prevent future deaths and I believe that the people listed in paragraph one above have the power to take such action.

8 YOUR RESPONSE

You are under a duty to respond to this report within 56 days of its date; I may extend that period on request.

Your response must contain details of action taken or proposed to be taken, setting out the timetable for such action. Otherwise, you must explain why no action is proposed.

9 **COPIES**

I have sent a copy of this report to the following:

- 1. Chief Coroner
- 2. Mrs Pierces' family
- 3. Surrey Heartlands Integrated Care System
- 4. Springfield Surgery
- 5. Royal Surrey County Hospital

10 Signed:

Susan Ridge

H.M Assistant Coroner for Surrey

Dated 19 August 2025