GRAEME HUGHES

HIS MAJESTY'S SENIOR CORONER

SOUTH WALES CENTRAL CORONER AREA

CORONER'S OFFICE
THE OLD COURTHOUSE
COURTHOUSE STREET
PONTYPRIDD
CF37 1JW

[redacted]

ANNEX A

REGULATION 28: REPORT TO PREVENT FUTURE DEATHS (1)

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

	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO:** 1. [redacted] **Minister for Health and Social Care for Wales;** 2. [redacted] **Interim Chief Executive and Registrar, General Pharmaceutical Council; and** 3. [redacted], **Chief Executive Digital Health and Care, Wales**
1	**CORONER** I am **Rachel Knight H M Coroner**, for the coroner area of South Wales Central.
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 31 January 2024 I commenced an investigation into the death of Lyn MAHER . The investigation concluded at the end of the inquest on 15/01/2026. The conclusion of the inquest was a narrative with the following cause of death: **1a hyperkalaemia** **1b Statin-induced rhabdomyolysis following clarithromycin treatment for lower respiratory tract infection (contraindicated medication)** **1c** **II Dilated Ischaemic Cardiomyopathy and acute on chronic kidney disease**
4	**CIRCUMSTANCES OF THE DEATH** These were recorded as :- Lyn Maher was aged 79 when on 3rd January 2024 she was prescribed clarithromycin for a chest infection, and part of her usual medication regime was simvastatin for high cholesterol. There is a well-known contraindication between these drugs. Lyn was not told to stop taking her statin by either her GP, nor by a community pharmacist dispensing the drug. On 10th January, she was issued with a further prescription for the same drug and again she was not told to stop taking her statin by GP nor a different community pharmacist. On 15th January Lyn was admitted to the Royal Glamorgan Hospital with a variety of symptoms and remained in hospital thereafter. At no point was Lyn asked about whether she had co-ingested the drugs and her statin continued to be given. Lyn's condition continued to deteriorate, and she became so weak she could not use her legs and could barely lift a spoon to her mouth. There was a missed diagnosis of rhabdomyolysis. There were missed opportunities by GP, community pharmacists and hospital clinicians to identify the co-ingestion of the contraindicated drugs. There were missed opportunities to stop the further administration of the statin at hospital. There were missed opportunities to test the creatinine kinase level which was undoubtedly rising. There was a missed diagnosis of rhabdomyolysis at hospital. Each of these factors more than minimally contributed to Lyn's tragic death which occurred following a cardiac arrest due to hyperkalaemia on 23rd January 2024 The Inquest focused upon:- - care and treatment from 3rd January 2024 until Lyn's death on 23rd January 2024 - Cause of death and the degree of contribution (if any) made by the concomitant ingestion of clarithromycin with simvastatin in the community, and the degree of contribution of other factors at hospital or generally

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 will occur unless action is taken. In the circumstances it is my statutory duty to report to you. The **MATTERS OF CONCERN** are as follows. (1) Evidence was heard that 2 separate community pharmacists did not tell Lyn, (nor pass a message via her family who collected the tablets), that she must stop taking simvastatin during the course of the clarithromycin, required for her chest infection. The pharmacists did not know she was taking simvastatin. I am concerned that there is confusion and a variety of opinion amongst community pharmacists around the extent of the expectation or duty to perform 'clinical checks' to enable safe prescribing and what that practically entails. (2) I am concerned that there is confusion amongst community pharmacists in Wales around the conflict between the expectation of safe prescribing/dispensing and patient confidentiality (when someone other than the patient collects the medication). (3) I am concerned that community pharmacists in Wales only have very limited access to the Welsh Clinical Portal, where they can see relevant drug history and recent test results, which would enable them to properly and safely counsel patients to stop contraindicated drugs (here simvastatin with clarithromycin) but applicable more widely. I heard evidence that access to such information is available routinely in English pharmacies, but only in exceptional circumstances in Wales. I have no understanding of why that is the case. (4) Here, had either community pharmacist had access to Lyn's drug history, they would have noted the contraindication and either told Lyn, her representative or written on the pharmacy bag that she was to stop the simvastatin. This likely would have changed the outcome for Lyn.
6	**ACTION SHOULD BE TAKEN** In my opinion action should be taken to prevent future deaths, and I believe you and 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 31st March 2026. 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 family, the GP and the pharmacists concerned who may find it useful or of interest. 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. She may send a copy of this report to any person who she 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	3 February 2026 **SIGNED:** [redacted] Rachel Knight H M Coroner for South Wales Central Coroner Area