	Senior Coroner, London Inner South, UK **Re: Michael Samuel Ian Anthony case ref 01269-2013** **REGULATION 28 REPORT TO PREVENT FUTURE DEATHS** **THIS REPORT IS BEING SENT TO:** **1. [redacted] general practitioner, PSGP, 2 Princess Street, London SE1 6JP** **2. [redacted] consultant physician, Older Persons Assessment Unit, Ground Floor, Bermondsey Wing, Guy's Hospital, Great Maze Pond, London SE1 9RT**
	CORONER I am Andrew Harris, senior coroner for the jurisdiction of London Inner South
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 14.05.13 I opened an inquest into the death of Michael Anthony, aged 64, who died on 8th May 2013. The inquest was concluded on 26th March 2014. The conclusion of the inquest was given in a narrative: *Mr Anthony was found dead in his flat on 8th May 2013. There were no suspicious circumstances. He died from diabetic ketoacidotic coma. He had a very high Gabapentin level in his blood, which along with a fatty liver from Hepatitis B and/or diabetes, contributed to his death. It was not possible to conclude whether the ketoacidosis was also caused by a reaction to Gabapentin.*
4	**CIRCUMSTANCES OF THE DEATH** The Gabapentin level was five times normal therapeutic level. It was not determined why this level was so high. His ketonuria was reported by the toxicologist as either being due to diabetic coma (shortage of insulin) and/or a reaction to the drug Gabapentin. The toxicologist reported that Gabapentin was usually not prescribed in diabetics, as some individuals developed a severe reaction which precipitated diabetic coma. The court read the evidence of the GP, who did not refer to the reasons for prescribing Gabapentin and did not call the consultant physician, but heard it was for pain relief. .
5	**CORONER'S CONCERNS** During the course of the inquest the evidence revealed a **MATTER OF CONCERN** as follows. – (1) It was not known whether Gabapentin was contraindicated to be prescribed in the deceased, who suffered severe Type 1 diabetes, or whether the prescribing doctors were aware of the rare side effect of Gabapentin in precipitating diabetic coma. If they were not there would be a potentially avoidable risk to other patients.

6	**ACTION SHOULD BE TAKEN** The doctors are asked to review the prescribing of this drug and its indications and consider whether it is appropriate to update their prescribing knowledge and practice.
7	**YOUR RESPONSE** You are under a duty to respond to this report within 56 days of the date of this report, namely by Thursday June 5th 2014. 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 Person, [redacted] sister. I have also sent it to [redacted] senior toxicologist, Imperial College, London. 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. If you would like further information about the case, please contact my officer, Miss Marianne Mitulescu, on 020 7525 1081, Marianne.mitulescu@southwark.gov.uk.
9	**[DATE]** 9th April 2014 **[SIGNED BY CORONER]**