Nicola Jane Mundy
Senior Coroner for South Yorkshire (East District)

	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO: Sir Andrew Cash,** Chief Executive, Northern General Hospital, Sheffield and The Chesterman Cardiothoracic Unit, Northern General Hospital, Sheffield
1	**CORONER** I am Nicola Jane Mundy, Senior Coroner for South Yorkshire (East District)
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. http://www.legislation.gov.uk/ukpga/2009/25/schedule/5/paragraph/7 http://www.legislation.gov.uk/uksi/2013/1629/part/7/made
3	**INVESTIGATION and INQUEST** On 28 January 2015 I commenced an investigation into the death of William Arthur Bows, aged 85 years. The investigation concluded at the end of the inquest on 28 July 2015. The conclusion of the inquest was a Narrative conclusion and the cause of death was: 1a Respiratory Failure, 1b. Diffuse Alveolar Damage, 1c. Amiodarone Toxicity, 2. Ischaemic Heart Disease
4	**CIRCUMSTANCES OF THE DEATH** This is an 85 year old man with medical history of heart bypass (2013), AF (treated with amiodarone),prostate problems, high BP and suffered with polymyalgia rheumatica. He was admitted to Bassetlaw Hospital on the 3rd Jan 15 due to increasing shortness of breath. He deteriorated further and on the 6th Jan was transferred to DRI where he was moved to the Intensive Care Unit. Blood cultures were normal with him having routine daily blood tests. Influenza swabs were normal. Echo cardiogram showed evidence of pulmonary hypertension and chest x-ray showed opacity in both lungs. Despite supportive treatment he continued to deteriorate. He passed away on 15th January whilst investigations were still ongoing.
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) There was no evidence of any protocols in place or guidance for advising primary care providers of the need to closely monitor patients who have been prescribed Amiodarone, particularly in relation to liver function tests, thyroid tests and respiratory difficulties. (2) With regard to the development of Amiodarone toxicity, I heard evidence that should this complication develop it usually does so within the first twelve months or so of commencing this drug and linked with (1) above, there was nothing before me to suggest primary care providers, or indeed secondary care prescribers, were taking steps to ensure there was adequate monitoring during this period.

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6	**ACTION SHOULD BE TAKEN** In my opinion action should be taken to prevent future deaths and I believe you [redacted] have the power to take such action. In the event there are policies dealing with how patients prescribed Amiodarone should be monitored and assessed, such protocols need to be reviewed to ensure that patients are properly followed up. This should ensure clear guidance as to how communications with Primary Care Healthcare providers should be informed.
7	**YOUR RESPONSE** You are under a duty to respond to this report within 56 days of the date of this report, namely by **22 September 2015**. 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] and NHS England (Northern Region). 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	Dated 28 July 2015 Signature [redacted] Senior Coroner for South Yorkshire (East District)

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