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. **General Dental Council** 2. **British Medical Association** 3. **Royal Pharmaceutical Society** 4. **Royal College of GPs** 5. **NHS England: Wales & Scotland**
1	**CORONER** I am Paul Jonathan Bennett assistant coroner, for the coroner area of Swansea.
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 the 5th November 2013 I commenced an investigation into the death of Patricia Margaret Thomas who was aged 79 years.. The investigation concluded at the end of the inquest on the 2nd March 2016. The conclusion of the inquest was that in relation to the medical cause of death, the deceased died on the 30th October 2013 at Morriston Hospital, Swansea from:- Ia) an intracerebral haemorrhage II Warfarin Treatment for Atrial Fibrillation, Miconazole Treatment of Oral Thrush. I recorded a narrative conclusion as follows:- That the deceased died from an intracerebral haemorrhage the effects of which may have been contributed to by the combined use of Warfarin and Miconazole gel medications..
4	**CIRCUMSTANCES OF THE DEATH** Mrs Margaret Patricia Thomas was found violently thrashing around in her bed by her husband at around 4.00am on the 30th October 2013. She was unresponsive and appeared to have left sided weakness. She was conveyed to Morriston Hospital A & E Department where she underwent blood tests and a CT scan. She was diagnosed as having suffered an intracerebral bleed causing a midline shift of the brain. No surgical intervention was recommended. Instead Mrs Thomas was made comfortable and she passed away just after 12.00pm that day. She had atrial fibrillation for which she took Warfarin. Some two weeks prior to her death she had presented to her NHS dentist complaining of symptoms consistent with oral thrush. She was prescribed Miconazole Gel by the dentist and this was dispensed in the form of Daktarin Gel by the local pharmacy. She was having regular INR checks and on admission it was noted to be greater than 10. Her usual range was between 2 and 3.

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 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. – It became apparent in the course of the evidence that (1) There is a potential for Miconazole Gel to have an interaction with Warfarin such as to increase the blood clotting time and hence a higher INR reading than should be expected. This could lead to significant uncontrolled bleeding. (2) There is a significant lack of knowledge of the interaction among health professionals and/or (3) The resources available to check the interaction may not be entirely clear on this issue or readily straight forward to locate.
6	**ACTION SHOULD BE TAKEN** In my opinion action should be taken to prevent future deaths and I believe your organisation has 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 the 10th May 2016. 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] (Husband); [redacted] (Dentist); Mr Andrew Gully (Branch Manager - Co-op Pharmacy). I have also sent it to the Chief Executive, ABMU LHB 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. 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	**7th March 2016** **Paul Jonathan Bennett**