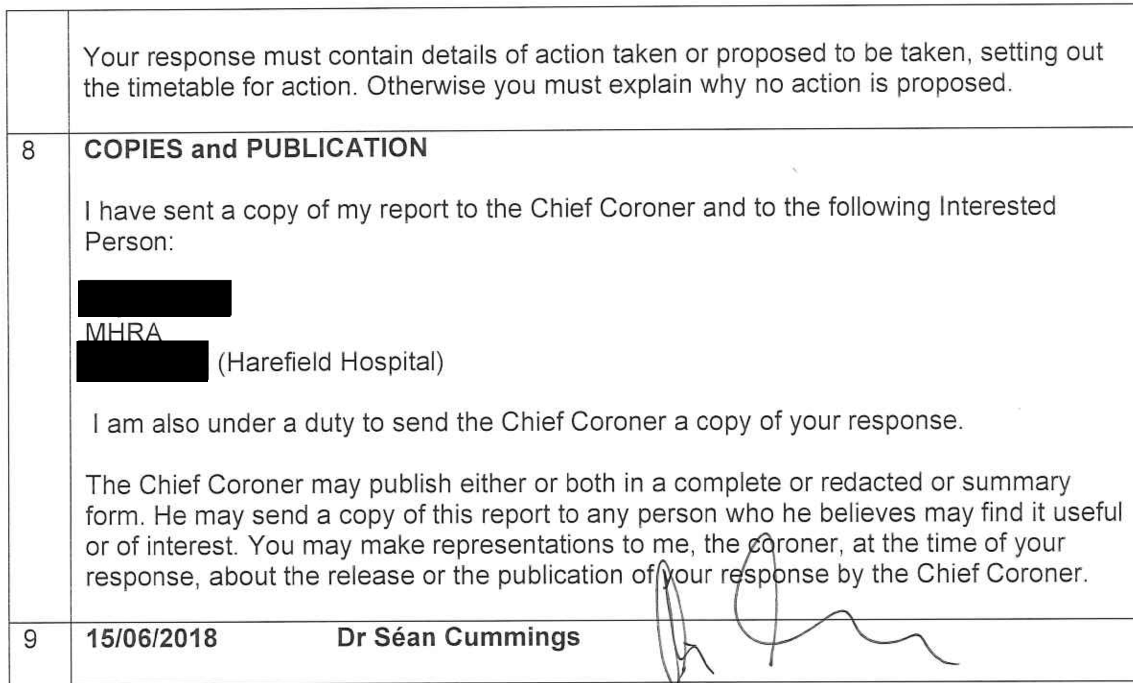
REGULATION 28: REPORT TO PREVENT FUTURE DEATHS

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

	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO:** **Chief Executive NHS England**
1	**CORONER** I am Dr Sean Cummings Assistant Coroner for the Coroner Area of West London
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 22/10/2017 I commenced an investigation into the death of Sneh Lata Chaudhry aged 56 years. The investigation concluded at the end of the inquest on 04/06/2018. The conclusion of the inquest was **Sneh Lata Chaudhry died from immediate complications following administration of an incorrect formulation of amphotericin.** The Medical Cause of Death was 1a Hyperkalaemia following amphotericin administration 1b multiorgan failure following high risk coronary surgery 1c triple vessel ischaemic coronary disease (off pump coronary artery bypass grafting 4/10/2017 II Diabetes mellitus, morbid obesity and asthma
4	**CIRCUMSTANCES OF THE DEATH** Ms Sneh Latta Chaudhry had high risk coronary artery bypass grafting on the 4/10/2017 at Harefield Hospital with a prolonged stay in ITU. She developed a systemic candida infection. She required treatment with amphotericin. The wrong preparation of intravenous amphotericin was given (Fungizone rather than Ambisone). An HCA obtained the wrong preparation from the ward drug stock. The administering nurse and the checking nurse did not notice that the wrong preparation was obtained and then administered. The drug vials have a similar appearance.
5	**CORONER'S CONCERNS** (1) Fungizone and Ambisone have a similar drug vial appearance and can be confused. Fungizone is typically used as aerosol and Ambisone as an intravenous preparation. Fungizone has a smaller therapeutic window and is more toxic and may lead to a fatal hyperkalaemia as in this case. (2) The nursing checks were described as passive rather than active
6	**ACTION SHOULD BE TAKEN** In my opinion action should be taken to prevent future deaths and I believe you 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 10/08/2018. 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: MHRA (Harefield Hospital) 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	**15/06/2018** **Dr Séan Cummings**