**ANNEX A**

**REGULATION 28: REPORT TO PREVENT FUTURE DEATHS (1)**

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

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| | **REGULATION 28 REPORT TO PREVENT FUTURE DEATHS**<br><br>**THIS REPORT IS BEING SENT TO:**<br><br>**The Chief Executive Cardiff & Vale University Health Board** |
| 1 | **CORONER**<br><br>I am Dr. Sarah-Jane Richards, HM Assistant Coroner, for the coroner area of South Wales Central. |
| 2 | **CORONER'S LEGAL POWERS**<br><br>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**<br><br>On 26 September 2018 an inquest was opened was into the death of Mr. Christopher Summerhayes otherwise known as Christopher Harrington. Enquires led by the Coroner's Office focused on the medical diagnosis and prescription management of this 29 year old man. In parallel, the family has undertaken its independent enquiries and the Inquest has been adjourned to allow those of the family's concerns which are within the scope of the Inquest, to be addressed as best as possible.<br><br>The family were concerned about a previous incident of acute collapse which occurred on 11 August 2018, 5 weeks prior to Christopher's death. The relevance being that upon emergency admission to the University Hospital of Wales, Christopher was correctly diagnosed as suffering from a pneumonia (adenovirus positive) and was successfully treated. However, the family had mis-understood the cause of this collapse was due to cardiac arrest which, had it been the case, would have required a full cardiac review. The family contends that had such a review been undertaken Christopher's coronary artery atherosclerosis noted at autopsy would have been identified, treated and his death avoided. This is subject of an investigation by the Concerns Co-ordinator, Cardiff and Vale University Health Board instigated at the request of the family. Open reading the medical reports provided to me, I have concluded the misunderstanding arose from a note taken at the scene of defibrillator use. While one was present no shocks were administered.<br><br>The Coroner's investigation concluded at the end of the inquest on the 20 August 2019. The medical cause of death was 1a. Ischaemic Heart Disease. The conclusion of the inquest was a narrative determination "*Atypical early onset coronary artery atherosclerosis on a background of a large number of prescribed complex medications"* |
| 4 | **CIRCUMSTANCES OF THE DEATH**<br><br>Mr. Christopher Summerhayes was found deceased at his home address. He had a significant medical history comprising multiple surgical interventions to treat his double scoliosis and treatment resistant schizophrenia. His medications numbered around 12 daily. Current advice to GPs is that an excess of 5 drugs requires concomitant protectant medications and places the patient at an increased risk of hospitalisation. Christopher |

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| | was prescribed the following 'complex' drug regime daily:<br><br>Analgesia: Morphine 60mg, Naproxen 1gm, Paracetamol 2-4gms and Pregabalin 600mg (also anti-anxiety);<br>Gastro protectant (from Naproxen): Omeprazole 20 mg;<br>Anti-psychotic: Aripiprazole 10mg and Clozapine 600mg - prescribed and monitored by the Community Mental Health Team (CMHT);<br>Anti-anxiety: Lorazepam up to 2mg - prescribed and monitored by CMHT<br>Hyperhidrosis: Oxybutynin 5mg<br>Laxative: Senna 28mg and Lactulose 18.6-22.2gm<br>Antibiotic: Doxycycline 200mg<br>Anti-acne: Zineryt lotion 90mls (topical application) |
| 5 | **CORONER'S CONCERNS**<br><br>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.<br><br>The **MATTERS OF CONCERN** are as follows. –<br><br>(1) In relation to Christopher Summerhayes, Clozapine was prescribed as a concomitant medication alongside approximately 11 other drugs including another anti-psychotic medication. Either alone or interaction with other prescribed medication, a large increase in weight occurred to >101kg (BMI 33.1) (reported side effect of clozapine) which had a 'knock-on' effect for his cholesterol and lipid levels and cardiovascular system. The usual dose is 200-450mg daily with the maximum dose being 900mg (BNF) which does not consider concomitant medications. Signs of prescription overdose include collapse and hallucinations which could be mistaken for unresolved symptoms of schizophrenias i.e. lack of drug efficacy encouraging dose increase. Blood levels of clozapine may rise in response to smoking cessation which Mr. Summerhayes had advised we was commencing.<br><br>(2) He may have suffered from a familial lipid disorder (present in other family members) which had it been confirmed would likely to have contraindicated Clozapine. |
| 6 | **ACTION SHOULD BE TAKEN**<br><br>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.<br><br>1. An adverse event report should be filed with the Medicines and Healthcare products Regulatory Agency in respect of Clozapine and the death of Mr. Summerhayes.<br><br>2. Where more than 5 medications are prescribed the drugs be examined by an associate physician or pharmacist for adverse interactions, either alone or in combination, which give rise to medical conditions which themselves predict hospitalisation and shorten longevity. Consideration would be for automatic referral to an individual qualified to assess i) drug-drug interactions; ii) the risks posed to the specific patient taking into account age, conditions suffered, lifestyle and the length of time the drug has been prescribed; iii) dosing levels be 'signed-off' by the qualified individual; and iii) all prescribing parties and the patient to be advised of the assessment outcome.<br><br>3. To de-prescribe where appropriate rather than accruing an increasing list of daily medications whereby further protectant medications are required to be prescribed with the risk of medication induced hospital admissions and risk to life.<br><br>4. Where there are two or more prescribing organisations (primary and secondary care) drug monitoring should be undertaken as mandated; by the responsible parties; and information promptly shared with all prescribers and their patients. |

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| 7 | **YOUR RESPONSE**<br><br>You are under a duty to respond to this report within 56 days of the date of this report, namely by 25 October 2019. I, the Coroner, may extend the period upon request.<br><br>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**<br><br>I have sent a copy of my report to the family who may find it useful or of interest.<br><br>Health Inspectorate Wales, Welsh Government; Cabinet Secretary for Health and Social Services; Chairman, Cwm Taf University Health Board; Medical Director of Cardiff and Vale Health Board. [redacted], South West Cardiff Community Mental Health Team; [redacted], Butetown Medical Practice; [redacted], NWSSP Legal & Risk Service; [redacted], Concerns Co-ordinator Cardiff & Vale UHB<br><br>I am also under a duty to send the Chief Coroner Mr. Marcus Lucraft QC a copy of your response.<br><br>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 | 22nd August 2019<br><br>**SIGNED:**  <br><br>Dr. Sarah - Jane Richards, HM Assistant Coroner for **South Wales Central** |