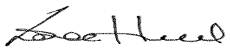
	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO:** **1. NHS England** **2. Clinical Commission Group**
1	**CORONER** I am Louise Hunt Senior Coroner for **Birmingham and Solihull**
2	**CORONER'S LEGAL POWERS** I make this report under paragraph 7, Schedule 5, of the Coroners and Justice Act 2009 and regulations 28 and 29 of the Coroners (Investigations) Regulations 2013.
3	**INVESTIGATION and INQUEST** On 26/04/2018 I commenced an investigation into the death of Sufia Begum. The investigation concluded at the end of an inquest on 20th August 2018. The conclusion of the inquest was:- Died from an unrecognised adverse drug interaction.
4	**CIRCUMSTANCES OF THE DEATH** The deceased was admitted to the Queen Elizabeth Hospital in Birmingham on 14/04/18 suffering from vomiting, confusion and generalised weakness. She had previously been treated at City Hospital for exacerbation of asthma from 07/04/18 – 09/04/18 and had been prescribed clarithromycin. Tests at the Queen Elizabeth Hospital confirmed she was suffering from an accumulation of verapamil (a calcium channel blocker drug she was already taking) caused by the prescription of clarithromycin which inhibits the enzyme which breaks down verapamil. It had not been recognised at the time that verapamil interacts with clarithromycin. Despite treatment she died on 24/04/18. Based on information from the Deceased's treating clinicians the medical cause of death was determined to be: MULTIORGAN FAILURE CALCIUM CHANNEL BLOCKER TOXICITY ATRIAL FIBRILLATION
5	**<u>CORONER'S CONCERNS</u>** 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. I heard evidence at the inquest that the most useful tool to identify potential drug interactions was the BNF mobile device APP. The author of the RCA confirmed that not all doctors were aware of the APP. An alert to all NHS Trusts and GPs would provide this valuable information which may prevent a future death from an unknown drug interaction.
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 15th November 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 Persons :- The family and Sandwell and West Birmingham Hospitals Trust. I have also sent it to CQC and Healthcare safety investigation branch 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	19/09/2018 Signature  Louise Hunt Senior Coroner **Birmingham and Solihull**