IN THE SURREY CORONER'S COURT

IN THE MATTER OF: ANN COLES

The Inquest Touching the Death of ANN COLES

A Regulation 28 Report – Action to Prevent Future Deaths

	THIS REPORT IS BEING SENT TO: • [redacted], **President of the Royal College of Physicians** • [redacted], **President of the Royal College of General Practitioners**
1	**CORONER** Caroline Topping, HM Assistant Coroner for the County of Surrey
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** An investigation into the death of Ann Coles was opened on the 4th April 2019. The Inquest was opened on 12th November 2019 and resumed and concluded on 16th March 2021. I concluded that Ann Coles was admitted to Frimley Park Hospital suffering with severe bilateral pneumonia and sepsis. Despite appropriate treatment she developed multi-organ failure and died on the 12th March 2019. The cause of death was: I a Multiple Organ Failure I b Sepsis

	I c Pneumonia II Aortic Stenosis I concluded she died of natural causes
4	**CIRCUMSTANCES OF THE DEATH** Ann had a tissue aortic valve replacement in 2014 having been diagnosed with severe aortic stenosis. She developed atrial fibrillation after the operation and required medication to revert to sinus rhythm. Thereafter she was prescribed amiodarone to prevent her relapsing into atrial fibrillation. She was subject to annual reviews thereafter. In March 2019 she was admitted to Frimley Park Hospital suffering with shortness of breath and found to have developed pneumonia. Despite appropriate treatment she died from multi-organ failure on the 12th March 2019.
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 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. – The evidence showed that a potential side effect of amiodarone medication is that it can cause toxicity which effects the lungs and can cause fibrotic changes. In her evidence the consultant cardiologist who treated Ann in her final illness raised the concern that there is no requirement for lung imaging to be undertaken when patients are prescribed amiodarone on a long term basis which in her view was a glaring gap in the oversight necessary for the effects of the medication. .
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 8th June 2021. 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 Frimley Park 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	**Signed:** **Caroline Topping** **Dated this 13th April 2021.**