Regulation 28: Prevention of Future Deaths report

Lauren Louise MURDOCK (died 23.10.21)

	THIS REPORT IS BEING SENT TO: **1. The Senior Partner** **Lathom Road Medical Centre** **2a Lathom Road** **East Ham** **London E6 2DU**
	CORONER I am: Coroner ME Hassell Senior Coroner Inner North London St Pancras Coroner's Court Camley Street London N1C 4PP
2	**CORONER'S LEGAL POWERS** I make this report under the Coroners and Justice Act 2009, paragraph 7, Schedule 5, and The Coroners (Investigations) Regulations 2013, regulations 28 and 29.
3	**INVESTIGATION and INQUEST** On 9 October 2021, I commenced an investigation into the death of Lauren Louise Murdock aged 27 years. The investigation concluded at the end of the inquest on 29 March 2022. I made a narrative determination at inquest, which I attach.
4	**CIRCUMSTANCES OF THE DEATH** Lauren Murdock died of a myocardial infarction. She was only 27 years old, but was at increased risk of this because she was obese, a smoker, had recently been prescribed the combined contraceptive pill, and then went on to develop hypertension. Also, at post mortem examination she was found to have myocardial hypertrophy.

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 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. Lauren Murdock was a patient of your practice. Her general practitioner (GP) described in court several changes made in the Lathom Road practice following Ms Murdock's death, but one issue remains outstanding. At inquest, I heard that Lauren visited the practice on 13 October 2021 and saw a healthcare assistant. Her blood pressure was taken and was found to be significantly elevated at 166/90, with a heart rate of 98. That blood pressure reading does not appear to have found its way to Ms Murdock's medical record, and it was certainly not brought to Dr [redacted] attention. That is a significant omission. 13 October 2021 is the first time that Ms Murdock's blood pressure was recorded as being elevated, and this was *after* the prescription of the combined contraceptive pill. She died ten days later.
6	**ACTION SHOULD BE TAKEN** In my opinion, action should be taken to prevent future deaths and I believe that 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 6 June 2022. 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 following.

	• [redacted], Lauren Murdock's parents • The Medicines and Healthcare Products Regulatory Agency • The Faculty for Sexual and Reproductive Healthcare (FRSH) • HHJ Thomas Teague QC, the Chief Coroner of England & Wales I am also under a duty to send a copy of your response to the Chief Coroner and all interested persons who in my opinion should receive it. I may also send a copy of your response to any other person who I believe may find it useful or of interest. 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.
9	**DATE** **SIGNED BY SENIOR CORONER** 05.04.22 *ME Hassell*

Regulation 28: Prevention of Future Deaths report

Lauren Louise MURDOCK (died 23.10.21)

	THIS REPORT IS BEING SENT TO: **1. Faculty of Sexual and Reproductive Healthcare (FRSH)** **Royal College of Obstetricians and Gynaecologists** **10-18 Union Street** **London SE1 1SZ**
	CORONER I am: Coroner ME Hassell Senior Coroner Inner North London St Pancras Coroner's Court Camley Street London N1C 4PP
2	**CORONER'S LEGAL POWERS** I make this report under the Coroners and Justice Act 2009, paragraph 7, Schedule 5, and The Coroners (Investigations) Regulations 2013, regulations 28 and 29.
3	**INVESTIGATION and INQUEST** On 9 October 2021, I commenced an investigation into the death of Lauren Louise Murdock aged 27 years. The investigation concluded at the end of the inquest on 29 March 2022. I made a narrative determination at inquest, which I attach.
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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 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. The general practitioner (GP) who prescribed Ms Murdock the combined contraceptive pill consulted the UK medical eligibility criteria (MEC) guidelines before she did so. However, she then miscalculated Ms Murdock's clot risk and she failed to calculate her cardiovascular risk. She miscalculated the clot risk because she did not appreciate the difference between a family member with history of clot over the age of 45 years, and one under the age of 45 years. If she had calculated correctly, she would have recognised that Ms Murdock was at higher risk and she would have taken a different course of action. She failed to calculate the cardiovascular risk because did not notice the relevant box in the MEC guidelines 11 page summary. If she had noticed the box, she would have recognised that Ms Murdock had multiple cardiovascular risk factors (obesity and smoking) and should only be prescribed Dianette following specialist consultation, if at all. The GP suggested that an auto calculator of risk might be one way to assist in the avoidance of such errors in the future.
6	**ACTION SHOULD BE TAKEN** In my opinion, action should be taken to prevent future deaths and I believe that 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 6 June 2022. 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.

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9	**DATE** **SIGNED BY SENIOR CORONER** 05.04.22 *ME Hassell*