	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO:** **1. Chief Executive, United Lincolnshire Hospital Trust, Lincoln County Hospital, Greetwell Road, Lincoln, LN2 5QY**
1	**CORONER** I am Stuart P G Fisher, Senior Coroner for the Coroner area of Central Lincolnshire, Lindum House, 10 Queen Street, Spilsby, Lincoln, Lincolnshire, PE23 5JE.
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 3 July 2009 I commenced an investigation into the death of Susan Jill Hammond aged 65 years. The investigation concluded at the end of the inquest on 30 October 2013. The cause of death was Anaphylactic reaction to the administration of intravenous augmentin. A narrative conclusion was given Mrs Hammond suffered a known allergy to penicillin despite this on 3 July 2009 a doctor prescribed augmentin (which is a penicillin based drug). This was administered to Mrs Hammond by an experienced nurse. A few minutes later Mrs Hammond suffered a cardiac arrest and despite attempts to resuscitate her she died at 0410 hours on 3 July 2009.
4	**CIRCUMSTANCES OF THE DEATH** In both 1992 and 2002 Mrs Hammond had been administered penicillin and had suffered Anaphylactic reactions on both occasions. Prior to her death Mrs Hammond was living in a nursing home. She became ill and was admitted to the Accident and Emergency department of Lincoln County Hospital on 2 July 2009. Despite the fact that there were a considerable number of warnings on the documents sent by the nursing home, documents within the hospital and the fact that Mrs Hammond was wearing a red allergy warning bracelet she was administered augmentin (being a penicillin based drug) she suffered a cardiac arrest and despite attempts to resuscitate her she died.
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. – [BRIEF SUMMARY OF MATTERS OF CONCERN] (1) Although there were written warnings of Mrs Hammond's allergy on hospital documentation they appear not to be have been noticed by the nurse who administered augmentin. In an effort to highlight the fact that a patient has an allergy I feel that there needs to be a much clearer indication on the file that the patient has such an allergy. At the inquest, it was suggested that a different coloured file should be used for any patient

	who has an allergy. Alternatively, a large sticker on the front of the file warning of the allergy would assist. (2) It appears that when Mrs Hammond transferred from the A&E unit to the EAU she was accompanied by a nurse who had little knowledge of Mrs Hammond's condition. As a consequence no discussion took place at the handover regarding the nature of Mrs Hammond's allergy to penicillin. It is felt that if the nurse who had cared for Mrs Hammond in the A&E department had personally accompanied her to the EAU this would have enabled a more productive handover and would have given an opportunity for discussion regarding the allergy. Although I appreciate there may be practical difficulties I would suggest that in future the nurse who has provided care for the patient in A&E should always accompany the patient to the EAU department in order that constructive handover can take place. (3) Your representative at the inquest hearing was not clear as to whether the doctor involved in this case was going to be referred to the General Medical Council and the nurse who administered Augmentin was going to be referred to the Nursing & Midwifery Council it was agreed that he would inform me of this within 14 days of conclusion of the inquest.
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 25 December. 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 Solicitors representing the family, and [redacted] and nurse [redacted] 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	**[DATE]** 4/11/13. **[SIGNED BY CORONER]**