REGULATION 28: REPORT TO PREVENT FUTURE DEATHS

This report is made under paragraph 7, Schedule 5, of the Coroners and Justice Act 2009 and regulations 28 and 29 of the Coroners (Investigations) Regulations 2013.

Recipients

This report is being set to:

- [redacted] Medical Director at Derriford Hospital, Plymouth

Coroner

I am Andrew James COX Assistant Coroner for the Coroner area of Plymouth, Torbay and South Devon.

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.

Investigation and Inquest

On 16 May 2013 an Inquest was opened into the death of Desmond Roy Statton, who died on 26 April 2013 then aged 81. The inquest was concluded at a hearing on 3 December 2013.

The cause of death was found to be:

1a	Allergic reaction to Contrast Medium
1b	
1c	
2	Infective Exacerbation of Chronic Obstructive Pulmonary Disease, Urinary Tract Infection and Coronary Artery Disease

The Conclusion of the Inquest was that Mr Statton died as the result of a known but rare complication following the administration of contrast medium.

Circumstances of death

Mr Statton was admitted to Derriford Hospital on 10 December 2012 for a TURP. In the Anaesthetic Room his back was sprayed with 0.5% Chlorhexidine and he was slowly given a 240 milligram dose of intravenous Gentamicin. Mr Statton complained that his back began to itch. He then became itchy everywhere felt sick

and vomited. He developed a tachycardia and was given adrenalin intravenously with Hydrocortisone and Chlorpheniramine. The procedure was abandoned.

Subsequently, Mr Statton was referred to the Anaesthetic Anaphylaxis follow up service where he was seen by [redacted]. He underwent skin prick and intradermal tests. By letter of 3 April 2013, [redacted] reported in the following terms:

"I think taking into account the history and skin test and also the severity of Mr Statton's respiratory problems he should avoid both Chlorhexidine and Gentamicin for any future procedures. It is important to note for future admissions to Hospital that Chlorhexidine is found in a number of preparations in addition to skin prep such as Instillagel as a coating on central lines and some mouth washes. Chlorhexidine is emerging as one of the more common causes of Anaesthetic Anaphylaxis and although Anaphalyaxis to Gentamicin is quite rare, his skin test results were convincingly positive".

On 26 April 2013 Mr Statton again attended Derriford Hospital for an Out-Patient Chest Clinic appointment. He presented in poor condition and the doctor was concerned to exclude a P.E. He suggested a chest X-ray and CT Scan.

At approximately 12 noon blood gasses were taken from Mr Statton. It is likely that immediately prior to the blood being taken, Mr Statton's skin was cleaned with a solution containing Chlorhexidine notwithstanding [redacted] guidance issued three weeks previously.

At approximately 2.30 that afternoon Mr Statton had a cannula inserted in preparation for the administration of Contrast Medium. Again it is likely that immediately prior to this procedure his skin was cleaned with a solution containing Chlorhexidine.

Mr Statton was then taken by wheelchair to undergo his CT Scan. Prior to the scan being undertaken, the Radiographer took the deceased's medical history and asked whether he suffered from any severe allergies. The form records that Mr Statton said that he did not.

The Radiographer checked on her computer system whether there were any alerts. She found none. In evidence, it was established that the Radiographer's computer system did not contain information relating to alerts and allergies contained on other computer systems available elsewhere in the Hospital. It was further established that the Radiographer did not know of the conclusions of [redacted] investigations .

Mr Statton was administered the Contrast Medium and almost immediately suffered a severe allergic reaction. Blood taken shortly after his collapse showed a mast cell tryptase level of 175 (normal 2 – 14). He was said to have developed a rash at the time of his collapse.

Mr Statton could not be resuscitated and died.

At Inquest, I found, as a matter of fact, that it was more likely than not that Mr Statton suffered an allergic reaction to the Contrast Medium rather than the Chlorhexidine

used to clean his skin on the two occasions prior to the CT Scan.

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.

1. 1. Radiographers are not able to access information concerning alerts or allergies contained on different computer programmes elsewhere in the Hospital.

1. 2. Derriford is a tertiary hospital and accepts admissions from other hospitals elsewhere in the South West. Clinicians in Derriford are not able to access information relating to alerts or allergies recorded on the computer programmes in other hospitals.

1. 3. Nursing staff are not sufficiently aware that Chlorhexidine is a growing cause of anaphylactic reactions and that it is contained within solutions used to sterilise the skin (and elsewhere.)

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.

Your response

You are under a duty to respond to this report within 56 days of the date of this report, namely by 29 January 2014. 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.

Copies and publication

I have sent a copy of my report to the Chief Coroner and to the following Interested Persons namely, [redacted], [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.

A J COX **Date 5 December 2013**
Assistant Coroner Plymouth, Torbay and South Devon area