REGULATION 28: REPORT TO PREVENT FUTURE DEATHS (2)

	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO:** **1. Dr John Rivers, Executive Chair and Clinical Director, The Isle of Wight Clinical Commissioning Group, Building A, The Apex, St Cross Business Park, Newport, Isle of Wight. PO30 5XW** **2. [redacted] Medical Director, Beacon Healthcare, St Mary's Hospital, Parkhurst Road, Newport, Isle of Wight, PO30 5TG**
1	**CORONER** I am Caroline Sarah Sumeray, Senior Coroner for the Coroner Area of the Isle of Wight.
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** On 7th April 2014 I commenced an investigation into the death of John William Day, aged 76. The investigation has now concluded and no inquest has been held. The medical cause of death was found to be: 1a Acute Exacerbation of Chronic Obstructive Pulmonary Disease 1b 1c II Cardiac Failure
4	**CIRCUMSTANCES OF THE DEATH** 1) John Day lived alone in a small flat which appeared to be within an assisted living environment with no care on site. He had respiratory issues and was on oxygen for much for the time. He suffered with COPD and heart failure. 2) During the evening of 5th April, Mr Day called a friend to say that he was having problems breathing. The friend called an ambulance for him as she was at work and unable to attend. 3) The ambulance crew arrived and advised that Mr Day should attend hospital. He refused as he has a Do Not Attempt Cardio Pulmonary Respiration (DNACPR) in place. The ambulance crew called for an on-call doctor from the Beacon to attend. Dr Oommen John attended and questioned Mr Day regarding any allergies, of which Mr Day said he had none, before prescribing him Prednisolone and Co-Amoxiclav.

	4) [redacted] did not have access to Mr Day's medical records. Had he been able to access them, he would have seen that Mr Day was, in fact, allergic to Co-Amoxiclav. 5) Mr Day was found dead in his chair whilst still attached to his oxygen supply, by his friend on 6th April 2014. 6) Mr Day's post-mortem showed that he had died of natural causes and that the Co-Amoxiclav had not caused an allergic reaction despite his known allergy to this drug.
5	**CORONER'S CONCERNS** During the course of the investigation my inquiries 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) During the course of my investigation, I heard live evidence from [redacted] who was the out-of-hours doctor who visited Mr Day. He told me that he did not have access to [redacted] medical records and that this was a common situation. He said that he had asked Mr Day if he had any allergies to medication, and Mr Day replied that he did not have any such allergies. Whilst Mr Day appeared to have capacity, the information which he gave to [redacted] was incorrect, and as a consequence, [redacted] prescribed Co-Amoxiclav to Mr Day. (2) In this case, the patient did not die as a result of the medication which was prescribed, but if the patient had died, an inquest would have inevitably resulted. Moreover, the patient had capacity to give an (incorrect) answer, but if the patient lacked capacity to do so, I am concerned that the out-of-hours doctor has no way of verifying the appropriateness of the medication which he wishes to prescribe. Accordingly I am concerned that there is not a way in which out-of-hours doctors can access the "Allergies" section of a patient's medical notes in every case. As I understand it, even if a patient opts out of the NHS Spine, the information about allergies should still be available to any medical personnel who consult the database.
6	**ACTION SHOULD BE TAKEN** In my opinion urgent action should be taken to prevent future deaths and I believe you and your organisation 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 Wednesday the 30th of July 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.

8	**COPIES and PUBLICATION** I have sent a copy of my report to the Chief Coroner and to the following Interested Persons: [redacted] and [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	 **H.M. Senior Coroner – Isle of Wight** **4th June 2014**