REGULATION 28: REPORT TO PREVENT FUTURE DEATHS

	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO: Right Honourable Jeremy Hunt M.P., Secretary of State for Health.**
1	**CORONER** I am John Pollard, senior coroner, for the coroner area of South Manchester
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 21st November 2013 I commenced an investigation into the death of Audrey Lily Kelly dob 16th September 1923. The investigation concluded on the 3rd April 2014 and the conclusion was that she died from natural causes. The medical cause of death was 1a Acute myocardial insufficiency 1b Coronary Artery atheroma II. Systemic Hypertension.
4	**CIRCUMSTANCES OF THE DEATH:** On the 17th November 2013 Mrs Kelly complained of abdominal pain and the out of hours doctor was called to attend. The doctor was unable to access her GP medical notes and was unaware that she was in fact known to be allergic to Trimethropim. He prescribed the antibiotic to her and she took three of the tablets as prescribed. She was then found deceased at her home two days later. The initial cause for concern was that she had consumed these tablets to which she was allergic, though in fact it turned out that the cause of her death was due to natural causes.
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. During the course of the evidence it was made very clear to me by the attending doctor who prescribed the medication and also by the nurse who took the call at the Out of Hours Service that they could not /are not allowed to obtain and see the electronic notes held by the patient's own GP. This fact was backed up by a senior administrator of the Out of Hours service who reiterated that neither they nor the hospital Emergency Departments, have direct access to GP Notes. It seems to me that this is a serious lapse in the procedures and will inevitably lead to further lives being lost when, if the notes were available, those lives might be saved. In the case of the Out of Hours service it seems particularly absurd that these notes are not available when in fact the Out of Hours doctor is deputising for that very GP who is

	not allowing access to the notes. It would appear therefore that there is an immediate need for directions to be issued to ALL OUT OF HOURS PROVIDERS and the appropriate Clinical Commissioning Groups to the effect that there must be free and unfettered access to ALL the GP notes in these circumstances.
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 **3 June 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 namely [redacted](daughter of the deceased),[redacted] clinical Director Mastercall Out of Hours service, Stockport. 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	**8 April 2014** **John Pollard, HM Senior Coroner**