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REGULATION 28: REPORT TO PREVENT FUTURE DEATHS

	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO:** The Chief Executive, East Kent Hospitals University NHS Foundation Trust
1	**CORONER** I am Rebecca Margaret COBB, Senior Coroner, for the Coroner area of North-East Kent
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 25th July 2013 I commenced an Investigation into the death of Nicos Andreas MICHAEL, aged 65 years. The Investigation concluded at the end of the Inquest on 1st April 2014. The conclusion of the Inquest was a Narrative (as set out in the first paragraph of box 4 below, the clinical cause of death being : 1a. Acute Anaphylaxis to intravenous penicillin. 2. Abdominal aortic aneurism (operated).
4	**CIRCUMSTANCES OF THE DEATH** Mr. Michael died on 1st November 2013 in Kent and Canterbury Hospital, Ethelbert Road, Canterbury, Kent as a result of an acute anaphylactic reaction to Augmentin that was administered intravenously to him at the hospital at around 5.15pm on 30th October 2013 in Kent Ward despite the existence of an old hospital record of a reaction to Augmentin, although there was conflicting evidence as to whether Mr. Michael had on this admission given information of penicillin being one of his allergies. He had informed his dentist of that allergy, but his GP only had a record of an adverse reaction to Ibuprofen. Mr MICHAEL was admitted to the hospital on 28th October 2013 for an elective repair of his abdominal aortic aneurism, which was carried out later that day. On 30th October 2013 his blood pressure was elevated, his oxygen saturations were low and he complained of feeling hot, dizzy and nauseous, although his temperature was within normal range. Ultimately, he was administered intravenous Augmentin antibiotic and almost immediately suffered a cardiac arrest which caused a significant brain injury from which recovery was not possible. Active treatment was withdrawn, with the consent of his family, and he died on the Intensive Care Unit on 1st November 2013.
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. – (1) There was no clear evidence (such as a document signed by Mr MICHAEL or a family member) detailing medication to which he/they was/were aware he was allergic. This led to there being conflicting evidence between his having (according to his son) highlighted his penicillin and Ibuprofen allergies to hospital staff and the allergy information for this admission recorded by hospital staff (which did not include penicillin but did include Ibuprofen). (2) The Root Cause Analysis conducted by the hospital into this death identified that Mr MICHAEL had three sets of hospital notes, in one of which there was a solitary entry to suggest that at a past medical attendance a reaction to Augmentin was noted. That information does not appear to have been translated in any subsequent entries nor to have been passed to his GP. (3)The importance of known or suspected allergies that have been recorded on previous contacts with a hospital being readily available to the hospital's staff when next treating that patient cannot be over-emphasised. There was evidence that the RCA team have sought learning from this event and how to record accurately and continuously highlight all known allergies or reported allergies, and how that information can be kept and made available on every patient at presentation. However, the evidence also showed that the medical reporting and computer systems for patient tracking do not currently allow this facility in such a way, although the relevant Trust teams are investigating how this data recording can be made more accurate. (4) Although the Trust has indicated that electronic prescribing should now be prioritised (which it considers could potentially have flagged up the historic allergy documentation), the RCA gave no indication that this would be compulsory for the future, or that any steps were being taken to encourage or make compulsory the checking of earlier paper records for information contained therein on allergies.
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 9th 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 Person: [redacted] I have also sent it to the Chief Executive of the Care Quality Commission and the Secretary of State for Health, Department of Health. 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	**14th April 2014** Rebecca Cohen