IN THE SURREY CORONER'S COURT
IN THE MATTER OF:

The Inquests Touching the Death of Marjory Rosina ELLERY
A Regulation 28 Report – Action to Prevent Future Deaths

	THIS REPORT IS BEING SENT TO: The Chief Executive of Frimley Park Hospital
1	**CORONER** Simon Wickens HM Assistant Coroner for Surrey
2	**CORONER'S LEGAL POWERS** I make this report under paragraph 7(1) of Schedule 5 to The Coroners and Justice Act 2009.
3	**INVESTIGATION and INQUEST** The inquest into **Marjory Rosina Ellery's** death was opened on the 26th February 2013 was resumed on 12th of November 2014. The Coroner found the cause of death was: 1a – Anaphylactic shock (clopidogrel and dalteparin related) 2 – Ischaemic heart disease due to coronary artery atheroma The Coroner returned a narrative conclusion: Marjorie Rosina Ellery died at 05.40 hours on the 16th January 2014 at Frimley Park Hospital following the administration of medication to which she was known to be allergic and which caused anaphylactic shock and subsequently death.
4	**CIRCUMSTANCES OF THE DEATH** On 15th January 2014 Marjorie Ellery was taken by ambulance to Frimley Park Hospital following her experiencing chest pains. She was seen by a staff nurse and her allergies to medications were noted and placed on red

	wristbands. Mrs Ellery was examined by an A&E doctor who prescribed Acute Coronary Syndrome Medications (ACS) - two of which Mrs Ellery was known to have an allergic reaction to. One of these medications (Clopigdogrel) had been prescribed despite a known allergic reaction in late 2013 when ACS Medications were administered. This was without problem. Dalteparin had not been prescribed at this time and an alternative was used. The Dr handed over the administration of the medications to a staff nurse. The staff nurse told Mrs Ellery she would be given three medications to which she was allergic but which she had been given in the past. The names of the medications were not given to Mrs Ellery and she had only received two of the three in the past. Soon after taking the medication Mrs Ellery became faint with signs of a rash. She suffered an anaphylactic shock and subsequently died on the 16th January 2014.
5	**CORONER'S CONCERNS** During the course of the inquest the evidence revealed a number matters that gave rise to a concern that circumstances creating a risk of other deaths will continue to exist in the future unless action is taken. The **MATTERS OF CONCERN** are as follows. – 1. Action is required to ensure that medication is not administered to a patient to which they are known to have an allergy without advice being sought from a doctor of appropriate designated seniority or experience. 2. Action is required to ensure that consent obtained from a patient as to the administration of medication to which there is a known allergy is informed consent.
6	**ACTION SHOULD BE TAKEN** In my opinion action should be taken to prevent future deaths and I believe that the Chief Executive of Frimley Park Hospital has the power to take such action.
7	**YOUR RESPONSE** You are under a duty to respond to this report within 56 days of its date; I may extend that period on request.

	Your response must contain details of action taken or proposed to be taken, setting out the timetable for such action. Otherwise you must explain why no action is proposed.
8	**COPIES** I have sent a copy of this report to the Interested Persons in the Inquest and the Chief Coroner.
9	**Signed:** *Simon Wickens* **DATED this 26th day of November 2014.**