ANNEX A

REGULATION 28: REPORT TO PREVENT FUTURE DEATHS (1)

*NOTE: This form is to be used **after** an inquest.*

	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO:** **1. Chief Executive of the Royal Devon and Exeter Hospital** **2. -** **3. -**
1	**CORONER** I am Dr Elizabeth Earland Senior Coroner for the coroner area of Exeter and Greater Devon.
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 7th October 2014 I commenced an investigation into the death of Alec James MATHIAS, 78 years old. The investigation concluded at the end of the inquest on 24th June 2015. The conclusion of the inquest was Misadventure with the Cause of Death of being – 1a – Liver Failure 1b – Flucloxacillin Induced Cholestatic Liver Injury 1c – Treatment for Cellulitis of the Left Index Finger II – Radiation Proctitis following Radiotherapy for Carcinoma of the Prostate
4	**CIRCUMSTANCES OF THE DEATH** Mr Mathias suffered from a whitlow of his Left Index Finger in June/July 2008 during which time he was treated with Flucloxacillin. He was admitted to the Royal Devon and Exeter (Wonford) Hospital on the 10th September 2008 with a presumptive diagnosis of painless obstructive jaundice under [redacted] following a GP letter dated 9th September 2008 to [redacted] Consultant Gastroenterologist (see p.4 statement of [redacted] dated 29.01.2015). It was found that he had suffered drug induced jaundice and the Flucloxacillin was stopped (further doses having been given while he was an in-patient). There is no record of a discharge summary being sent to Mr Mathias's GP or that he had suffered a reaction to the Flucloxacillin and that this had been the agreed cause of his liver problems. Mr Mathias suffered further infection of the index finger in August 2014 and was again prescribed Flucloxacillin by the GP practice nurse, which proved fatal – see Record of Inquest.

	I received evidence from [redacted]re September 2008 admission and [redacted] and [redacted] regarding the 22nd August 2014 admission and it is clear that not only was no discharge letter sent to the GP in 2008 alerting the practice to Mr Mathias's idiosyncrasy regarding Flucloxacillin but there was no highlighting of the hospital notes that he had an allergy or would suffer a reaction if given Flucloxacillin. The administration of Flucloxacillin has caused Mr Mathias's death.
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) Discharge letters have not been sent to the patients GP in a case where a dangerous side effect to treatment has been noted (2) That the hospital has not highlighted its own records with vital information on drug sensitivity discovered and diagnosed on an in-patient.
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 21st August 2015. 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. 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	**26th June 2015** **[SIGNED BY CORONER]**