DAVID W. G. RIDLEY
Senior Coroner for Wiltshire and Swindon

	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO:** Ms Nerissa Vaughan Chief Executive Great Western Hospitals NHS Foundation Trust Great Western Hospital Marlborough Road Swindon SN3 6BB
1	**CORONER** I am DAVID RIDLEY, Senior Coroner for Wiltshire and Swindon
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. http://www.legislation.gov.uk/ukpga/2009/25/schedule/5/paragraph/7 http://www.legislation.gov.uk/uksi/2013/1629/part/7/made
3	**INVESTIGATION** On 14/12/2016 I commenced an investigation into the death of Joyce Violet Rumming who was born on 2nd September 1931. Violet died at The Great Western Hospital in Swindon on 12th December 2016. The Investigation was commenced as information was supplied in order to make the decision that a post mortem was required that whilst at The Great Western Hospital Joyce may have been given antibiotics in respect of which she was allergic to. I was informed that there had been a previous occasion that resulted in a reaction. As such the investigation post mortem itself was carried out at Salisbury District Hospital because of the possible conflict of interest.
4	**CIRCUMSTANCES OF THE DEATH** Joyce had arrived at the Accident and Emergency Department of The Great Western Hospital late on the 11th December 2016, she was alert and orientated and appeared to respond clearly to questioning. She had previously been diagnosed with a chest infection in respect of which she had recently completed a course of antibiotics. The Ambulance Acute Referral Form identified that Joyce was allergic to Amoxicillin but it does not appear that this was conveyed to those in the Emergency Department room at handover. The allergy does not appear to have been picked up by the Emergency Department room staff when considering the Ambulance Acute Care Referral Form. Shortly before midnight one of the nurses in consultation with the patient's son and husband present documented an allergy to Amoxicillin on the reverse of the Care Plan. Joyce, to confuse matters had also stated to another nurse when asked that she had no allergies although there appears to have been a concern that she may have been concerned. A Doctor having checked the internal Medway System and a ED CAS card went on to prescribe Amoxicillin in respect of which Joyce apparently had an allergy following a previous reaction. It would appear that the allergy following a previous admission was recorded on the EPMA System (not used in the ED) and not on Medway which is accessible in the ED. It would appear that on the previous admission that the allergy had also been documented on the drugs chart. The Amoxicillin and Clarithromycin were administered at 01.45 on the 12th December 2016 and sadly Joyce passed away just over ½ hour later. Having made further enquiries the cause of death

	highlighted that Joyce's death was due to respiratory failure but that it did not appear to be related to an allergic reaction to the Amoxicillin. It will shortly be the case that the investigation will be discontinued on the basis that the cause of death appears to be natural and [redacted] suggests the following as a cause of death which I have no reason to reject:- 1a) Type II respiratory failure and respiratory acidosis 1b) Large sliding hiatus hernia 2) Chronic asthma, recent lower respiratory tract infection and coronary artery atherosclerosis.
5	**CORONER'S CONCERNS** Helpfully a Route Cause Analysis was undertaken which highlighted as a care service delivery problem the fact that an antibiotic, Amoxicillin, in respect of which it was believed that Joyce was allergic to following a previous allergic reaction had been given to her shortly before her death. The Route Cause Analysis in relation to items (bullet points) under contributory factors documents a number of areas that give rise for concern. It essentially amounts to right hand not communicating with the left hand in that for example unless a Doctor looks in a specific location due to issues as regards the communication between various software packages that the existence of an allergic marker could easily be missed as was the situation in relation to Joyce's case. A number of recommendations have been highlighted which have been documented at items 1-4 in the action plan. I share the concerns highlighted by the Route Cause Analysis and the purpose of this Regulation 28 Report is to enable a mechanism whereby your Trust feeds back both to myself and to the family the results of the recommendations and provides details in respect of what changes will be made and if changes cannot be made as to why they cannot be made. Proceeding in this way will allow the family to secure a full death certificate following discontinuance which will take place a few days after this Regulation 28 Report is sent out. I have attached for ease of reference Appendix A which contains the 4 recommendations.
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 normally under a duty to respond to this report within 56 days of the date of this report, namely by the 1st August 2017. I am however aware that the due date in relation to dealing with all the points is in the future and therefore I have extended the period for response until Friday the 15th September 2017.
8	**COPIES and PUBLICATION** I have sent a copy of my report to the Chief Coroner and to the following Interested Persons [redacted] I have also sent it to [redacted] Director of Commissioning (South Central) NHS England Bewley House Marshfield Road Chippenham Wiltshire SN15 1JW

	who may find it useful or of interest. 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	Dated 06 June 2017 Signature  Senior Coroner for Wiltshire and Swindon