Hassan Shah, Assistant Coroner for the County of Northampton, Constabulary Block, Angel Street, Northampton, NN1 1ED
Email: Coroners.office@northamptonshire.gov.uk Tel: 01604 363102

	REGULATION 28 REPORT ON ACTION TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO:** 1. Creators/administrators of CAMIS medical records system 2. The Rt Hon Matt Hancock MP, Secretary of State for Health and Social Care
1	**CORONER** I am Mr Hassan Shah, Assistant Coroner for the coroner area of Northampton.
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 the 04/07/2018 I commenced an investigation into the death of Mrs Ann Patricia Ellen Schuetz. The investigation concluded at the end of an inquest on 24/11/2020. The medical cause of death was determined to be:- 1a Multi organ failure 1b Hypoxic cardiac arrest 1c Angioedema secondary to Angiotensin-converting enzyme inhibitor 2 Large brain infarct
4	**CIRCUMSTANCES OF THE DEATH** Mrs Ann Patricia Ellen Schuetz died on 26th June 2018 at NGH as a result of an allergic reaction to Ramipril, medication prescribed for hypertension. Mrs Schuetz was seen at Northampton General Hospital (NGH) and by her GP practice numerous times between 2015 - 2018. Several of the attendances to hospital were due to angioedema which on some of the attendances was noted to be a reaction to Ramipril, the Angiotensin-converting enzyme inhibitor medication she was taking to manage her high blood pressure. Despite this diagnosis, this information was not added as an allergy on either Symphony, ePMA or on the Electronic Discharge Notification forms. It was also not coded as an allergy on the GP's electronic system. During an admission to hospital in November 2017 Mrs Schuetz became hypertensive. Ramipril was re-started as there was no contraindication in the medical notes. The GP practice then continued to prescribe the Ramipril as it was not coded as an allergy on the GP system. In June 2018, Mrs Schuetz had another allergic reaction and was admitted to NGH. Despite intensive treatment and interventions, Mrs Schuetz sadly died on 26th June 2018.

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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 could occur unless action is taken. In the circumstances it is my statutory duty to report to you. The **MATTERS OF CONCERN** are as follows:- In the present case, the allergy was not recorded in the appropriate places in the relevant electronic systems. A contributing factor was that that primary and secondary care have a number of different electronic systems in place to manage patient medical information including:- 1. Symphony – Emergency Department system 2. EDN – Electronic Discharge Notification system 3. ePMA – Electronic prescribing system 4. SystemOne – Electronic GP documentation system 5. CAMIS – Overview system which holds such details as ID and all attendances including outpatient One of the root causes according to the Trust's Investigation report was *"the fact that the electronic patient systems used in primary and secondary care did not have the ability to share information and therefore the updated allergy information was required to be inputted manually into each system…."* The Trust is continuing to explore the feasibility of having regional central medical records but it is not known if any other Trusts are doing the same. The Investigation report also states that *"The CAMIS system currently does not have anywhere to record a patient's allergies. If a change is to be made to the CAMIS system, this would need to be changed nationally".*
6	**ACTION SHOULD BE TAKEN** In my opinion action should be taken to prevent future deaths and I believe you AND/OR your organisation, have the power to take such action. You should consider a review of the medical records system, including in relation to the recording of allergies.
7	**YOUR RESPONSE** You are under a duty to respond to this report within 56 days of the date of this report, namely by **Wednesday 27 January 2021**. 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.

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8	**COPIES and PUBLICATION** I have sent a copy of my report to the Chief Coroner and to the following Interested Persons:-. **Deceased's daughter.** **Northampton General Hospital NHS Trust.** Similarly, you are 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.
9	*H Shah* – ***Mr H Shah – Assistant Coroner, Northamptonshire*** **24th November 2020**