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| | **REGULATION 28 REPORT TO PREVENT FUTURE DEATHS**<br><br>**THIS REPORT IS BEING SENT TO:**<br>1. Tettenhall Medical Practice; |
| 1 | **CORONER**<br>I am Mrs Joanne Lees, Area Coroner, The Black Country Jurisdiction |
| 2 | **CORONER'S LEGAL POWERS**<br><br>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**<br><br>On 15/9/20 I conducted an inquest touching the death of the late Eileen Brindley who died on the 28th August 2020 at New Cross Hospital, Wolverhampton, West Midlands.<br><br>Having considered all the available evidence, I, the Coroner made the following findings of fact;<br><br>'On 28/8/20 the deceased a frail 97-year-old lady was admitted to hospital having been found by her carer struggling to breath. She was believed to have suffered a severe allergic reaction and sadly passed away in hospital shortly afterwards. She was known to be allergic to Flucloxacillin and had recently been prescribed a penicillin type antibiotic for and throat/ear infection'.<br><br>The Medical Cause of Death was:<br><br>1a) Anaphylaxis<br><br>The inquest concluded with a short form conclusion of accidental death |
| 4 | **CIRCUMSTANCES OF THE DEATH**<br><br>i) On the evening of 28/8/20 the deceased was admitted to New Cross Hospital having been found at home by her carer struggling to breathe;<br>ii) On arrival of the emergency services she was she was noted to be in severe respiratory distress with a GCS of 6;<br>iii) On arrival in the ED at approximately 10 pm she was noted to have a gcs 3/15, breathing laboured, Sats on air 69%, wide spread urticarial rash to chest and back;<br>iv) She was treated with back to back nebulisers, iv hydrocortisone, iv Chlorphenamine, magnesium and iv fluids with no improvement;<br>v) Her breathing worsened, and she was confirmed as deceased at approximately 10.32 pm;<br>vi) Paramedic's reported on arrival at the address a box of Flucloxacillin was found by the deceased and stated some had been taken and that the deceased had previously suffered a severe |

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| | adverse reaction to Flucloxacillin which was documented in her previous hospital attendances;<br>vii) Information provided by the Medical Examiner was that the cause of death on a balance of probability was 1a) Anaphylaxis, and that the deceased Mrs Brindley was found to be allergic to Fluclox during an admission in April 2020, and this was highlighted on her discharge summary;<br>viii) A print out from the deceased GP Practice Tettenhall Medical Practice revealed an entry dated 3/7/20 under the heading ***Allergies*** '***Adverse reaction to Flucloxacillin***';<br>ix) The same print out revealed a telephone prescription was made for Amoxicillin on 21/8/20 for a throat/ear infection;<br>x) The Medical Examiner at New Cross Hospital concluded the deceased had died from an allergic reaction irrespective of whether the drug found was Flucloxacillin or Amoxicillin and that any penicillin should not have been prescribed. |
| 5 | **CORONER'S CONCERNS**<br><br>During 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.<br><br>The **MATTERS OF CONCERN** are as follows. –<br><br>1) That a prescription was issued for a penicillin type antibiotic on 21/8/20 despite an entry in the medical records of the deceased highlighting a previous adverse reaction to Flucloxacillin;<br><br>2) There was no evidence that the prescribing clinician had noted the adverse reaction entry and/or there was no explanation why the medication had been prescribed even if that entry had been noted;<br><br>3) The prescription was issued with any consultation either in person or over the telephone;<br><br>4) That entries into medical records are not sufficiently highlighted to any clinician who is unfamiliar with the previous medical history of the deceased; |
| 6 | **ACTION SHOULD BE TAKEN**<br><br>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.<br><br>Tettenhall Medical Practice may wish to review how allergies are recorded within electronic patient records.<br><br>The GMC may wish to review the actions of the prescribing Doctor and consider whether any further action is necessary. |
| 7 | **YOUR RESPONSE** |

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| | **<u>You are under a duty to respond to this report within 56 days of the date of this report, namely by 20/11/20.</u>** I, the coroner, may extend the period.<br><br>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**<br><br>I have sent a copy of my report to the Chief Coroner and to the following Interested Persons [redacted], son of the deceased.<br><br>I have also sent a copy of my report to the GMC.<br><br>I am also under a duty to send the Chief Coroner a copy of your response.<br><br>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 |  <br>**<u>Mrs Joanne M. Lees</u>**<br>**<u>Area Coroner</u>**<br>**<u>The Black Country Jurisdiction</u>**<br>**<u>24/9/20</u>** |