MR G IRVINE
ACTING SENIOR CORONER
EAST LONDON
Walthamstow Coroner's Court, Queens Road Walthamstow, E17 8QP
[redacted]

REGULATION 28: REPORT TO PREVENT FUTURE DEATHS (1)

[redacted]

	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO:** 1. Dr [redacted] – Hainault Surgery, 34 New North Road, Hainault Ilford IG6 2XG - [redacted] 2. Dr [redacted] Sma Medical Practice, London, E10 6RA - [redacted]
1	**CORONER** I am Graeme Irvine, acting senior coroner, for the coroner area of East London
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 and INQUEST** On 29TH July 2020 I commenced an investigation into the death of Samantha Singh, 26 years old. The investigation concluded at the end of the inquest on 22nd June 2021. The conclusion of the inquest was cause of death: 1a Anaphylactic shock 1b Allergy to nuts

	A short form conclusion of accidental death was arrived at.
4	**CIRCUMSTANCES OF THE DEATH** Miss Samantha Singh attended her general practitioner's surgery in November 2019 to raise a concern regarding her suspicion that she suffered from a nut allergy. Following a RAST test Miss Singh was assessed to suffer from a mixed nut allergy, she was prescribed an EpiPen. On 25 July 2020 Miss Singh became unwell at home and suffered a cardiac arrest attributable to anaphylactic shock. Despite best efforts of her family and emergency services she could not be resuscitated.
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. – (1) Results of Miss Singh's RAST test were wrongly categorised by the surgery as normal. As such, no further action was indicated by the surgery. It was only Ms Singh's perseverance that led to a follow-up appointment being arranged to discuss the results with her GP where the mistake was discovered (2) At a GP appointment on 27 November 2019, Miss Singh was prescribed a single EpiPen, NICE guidance at the time indicated that no fewer than two epi-pens should be prescribed to a patient. (3) Following the appointment on 27 November 2019 Miss Singh was not referred to allergy clinic or offered a follow-up appointment to address issues arising from her allergy diagnosis.
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.
7	**YOUR RESPONSE** You are under a duty to respond to this report within 56 days of the date of this report, namely by **27th August 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.
8	**COPIES and PUBLICATION** I have sent a copy of my report to the Chief Coroner and to the following Interested Persons the family of Ms Singh, the CQC and GMC. I have also sent it to the Director of Public Health who may find it useful or of interest. I am also under a duty to send a copy of your response to the Chief Coroner and all interested persons who in my opinion should receive it. I may also send a copy of your response to any other person who I believe may find it useful or of interest.

	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	**[DATE] 02/07/2021** **[SIGNED BY ACTING SENIOR CORONER GRAEME IRVINE]**