IN THE WEST YORKSHIRE (WESTERN) CORONER'S COURT
IN THE MATTER OF:

The Inquest Touching the Death of Sharon Anne ROBINSON
A Regulation Report – Action to Prevent Future Deaths

REGULATION 28 REPORT TO PREVENT DEATHS

THIS REPORT IS BEING SENT TO:

1 [redacted] – Chief Executive - Bradford Teaching Hospitals NHS Trust

2 Dr [redacted] – Chief Medical Officer – Bradford Teaching Hospitals NHS Trust

1 CORONER

I am Dr Anthony HOWARD, HM Assistant Coroner for the area of West Yorkshire Western Coroner Area

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 Nineteenth February 2019 I commenced an investigation into the death of Sharon Anne ROBINSON aged 56. The investigation concluded and at the end of the inquest the conclusion of the inquest was:

I a Hypoxic Brain Injury
I b Cardiac Arrest
I c Treated chest infection (with amoxicillin anaphylaxis)

II

4 CIRCUMSTANCES OF THE DEATH

Narrative Conclusion:
Sharon Robinson died on the 7th February, 2019 at Airedale Hospital as a result of administration of an Antibiotic on the 27 January which induced an anaphylactic reaction.

5 CORONER'S CONCERNS

The MATTERS OF CONCERNS are as follows: There is a concern that when a patient may have a sensitive to anti-biotic despite the low risk, this will be ignored and anti-biotic be given in any event.

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 4th January 2022. 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 next of kin who may find it useful.

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

Dr Anthony HOWARD
HM Assistant Coroner for
West Yorkshire Western Coroner Area
Dated: 16 November 2021