CORONER'S OFFICE
AREA OF HERTFORDSHIRE

Date: 10 February 2022

[redacted]

REGULATION 28 REPORT TO PREVENT FUTURE DEATHS

THIS REPORT IS BEING SENT TO: [redacted] **Chief Executive of NHS England**

1. **CORONER**
   I am Graham Danbury Assistant Coroner for Hertofdshire

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 18 May 2020 I commenced an investigation into the death of John Paul SKINNER.

   The Investigation concluded at the end of the inquest on 4 November 2021.

   The conclusion of the Inquest was Mr Skinner was admitted to Watford General Hospital suffering tonic clonic seizures. The doctors caring for him decided to administer Phenytoin, an anti-epileptic medication. The junior doctor instructed to administer the drug sought advice from a more senior doctor as to the dose to be administered. As a result of a failure in verbal communication between the doctors, aggravated as both were masked, a dose of 15 mg/kg was heard as 50 mg/kg and an overdose was administered.

   1a Acute Cardiac Failure

   1b Phenytoin Toxicity

   1c

   II Chronic Ischaemic Heart Disease, Urolithiasis

4. **CIRCUMSTANCES OF DEATH**
   On the 15th May 2020 John Skinner was admitted to Watford Hospital suffering from a tonic clonic seizure he had a background of cannabis usage and a subdural empyema in 2010 that had left him with epilepsy. On arrival at hospital he again had another tonic clonic seizure and focal seizures. He was given 3500 mg of phenytoin. He arrested within 15 minutes and died and could not be revived.

5. **CORONERS 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 will 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) The junior doctor instructed to administer phenytoin did not know the required dosage and asked his more senior colleague for advice. The senior doctor's reply 15kmg/kg was heard by the junior doctor as 50mg/kg resulting in administration of a significant overdose.

This is a readily foreseeable confusion which could apply in any hospital and could be avoided by use of clearer and less confusable
means of communication and expression of number

6. **ACTION SHOULD BE TAKEN**
In my opinion action should be taken to prevent future deaths and I believe you NHS England 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 12th April 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 following Interested Persons [redacted] partner of John Skinner.

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 10 February 2022

Signature

Assistant Coroner for Hertfordshire

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