

Regulation 28: REPORT TO PREVENT FUTURE DEATHS

NOTE: This form is to be used **after** an inquest.

REGULATION 28 REPORT TO PREVENT DEATHS

THIS REPORT IS BEING SENT TO:

1 Chief Executive Portsmouth Hospitals NHS Trust

1 CORONER

I am Jason PEGG, Area Coroner for the coroner area of Hampshire, Portsmouth and Southampton

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 29th September 2020 I commenced an investigation into the death of Beatrice Florence May DAWKINS aged 82. The investigation concluded at the end of the inquest on 4th April 2022. The conclusion of the inquest was that:

The deceased died on 20th September 2020 at Queen Alexandra Hospital, Portsmouth, Hampshire. On 20th September 2020 the deceased suffered an anaphylactic reaction to chloramphenicol administered to treat a urinary tract infection, the reaction is a rare but recognised complication of using chloramphenicol. Records relating to the deceased's sensitivity to chloramphenicol were not readily available and were not identified prior to the administration of the chloramphenicol.

4 CIRCUMSTANCES OF THE DEATH

Misadventure

5 CORONER'S CONCERNS

During the course of the investigation my inquiries 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:

(brief summary of matters of concern)

The deceased's medical notes contained at least seven entries indicating the deceased had a sensitivity to chloramphenicol, the first such entry being recorded in 1997.

Those medical notes included notes made by the Queen Alexandra Hospital, Portsmouth in which the deceased's recorded allergies included chloramphenicol.

Evidence was adduced that had the clinicians involved in the care and treatment of the deceased in September 2020 had knowledge of those notes and/or the deceased's sensitivity to chloramphenicol had been flagged in the medical records during the deceased's September 2020 admission chloramphenicol would not have been prescribed to the deceased.

My concern is that relevant, critical information relating to the care and treatment of the deceased was in existence but was not accessible nor flagged up to those involved in the



care and treatment of the deceased.

In the absence of a process where relevant, critical information is not accessible nor flagged up to clinicians there continues to be a future risk to life.

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 May 31, 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

I have also sent it to

Louise Astill Medicare (Instructed by the family)

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 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 by the Chief Coroner.

9 Dated: 05/04/2022

Jason PEGG Area Coroner for Hampshire, Portsmouth and Southampton