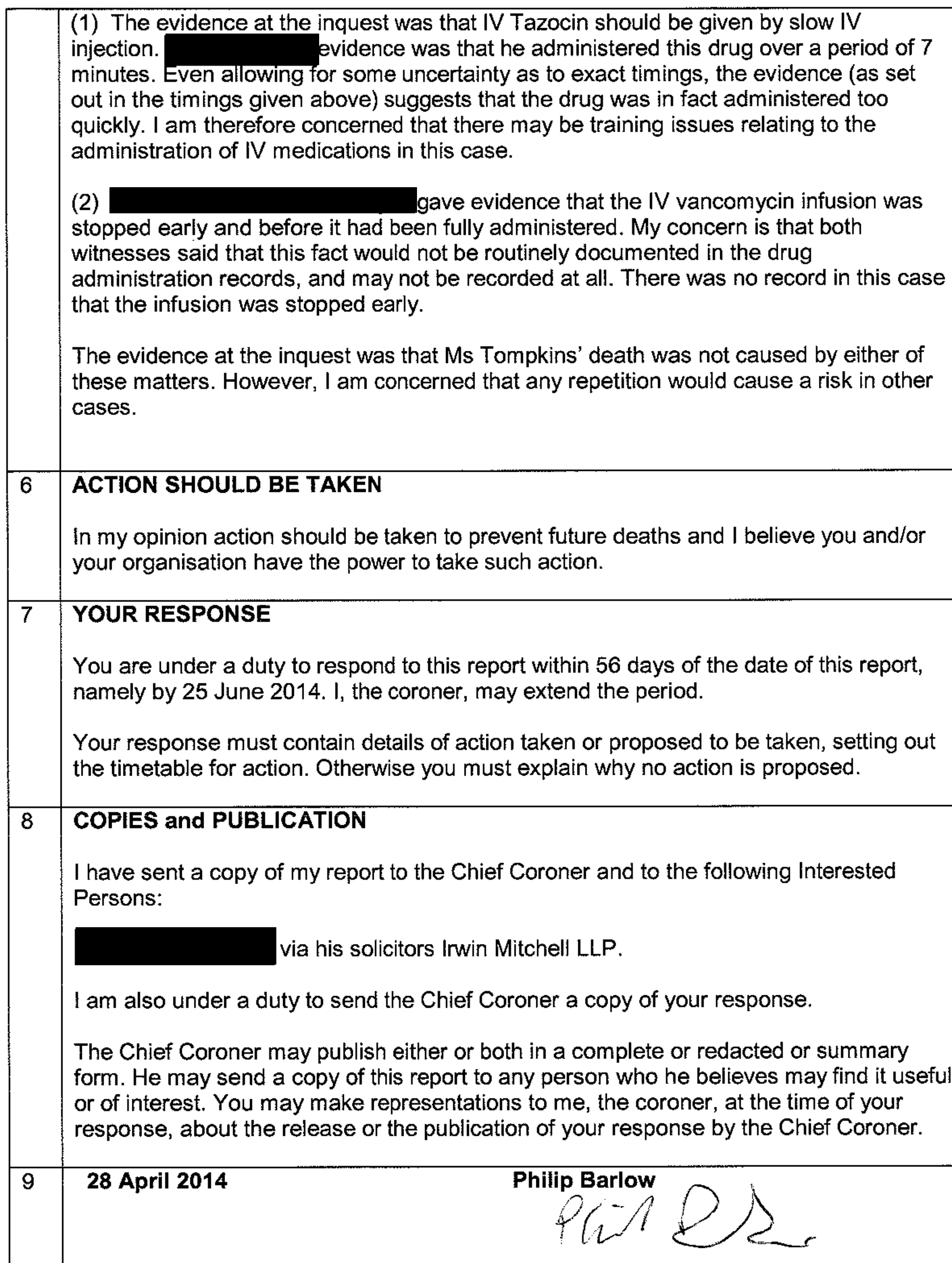
ANNEX A

REGULATION 28: REPORT TO PREVENT FUTURE DEATHS (1)

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

	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO:** 1. **Tim Smart, Chief Executive, Kings College Hospital NHS Foundation Trust**
1	**CORONER** I am Philip Barlow, assistant coroner, for the coroner area of Inner London South
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. [HYPERLINKS]
3	**INVESTIGATION and INQUEST** On 8 July 2011 I commenced an investigation into the death of Jennifer Tompkins, age 37. The investigation concluded at the end of the inquest on 10 April 2014. The narrative conclusion of the inquest was that Jennifer Tompkins suffered fatal allergic anaphylaxis after receiving an intra venous injection of Tazocin on 6 July 2011 at Kings College Hospital.
4	**CIRCUMSTANCES OF THE DEATH** Ms Tompkins had focal segmental glomerulosclerosis and was undergoing dialysis while awaiting a kidney transplant. On 6 July 2011 she was admitted to KCH under the care of [redacted] A CT scan suggested that Ms Tompkins had an infected pelvic fluid collection for which she was prescribed IV vancomycin and Tazocin, along with cyclizine. These drugs were administered by staff nurse [redacted] The vancomycin infusion was commenced at 20.07 and the IV cyclizine was given at 20.55 followed by the IV Tazocin. After receiving the Tazocin Ms Tompkins suffered allergic anaphylaxis. The cardiac arrest team were called at 21.00 and arrived at 21.04. Sadly, resuscitation attempts were unsuccessful. During the inquest I heard from several witnesses including [redacted] and expert evidence from [redacted], reader in clinical pharmacology at Royal Hallamshire Hospital, Sheffield.
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 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 evidence at the inquest was that IV Tazocin should be given by slow IV injection. evidence was that he administered this drug over a period of 7 minutes. Even allowing for some uncertainty as to exact timings, the evidence (as set out in the timings given above) suggests that the drug was in fact administered too quickly. I am therefore concerned that there may be training issues relating to the administration of IV medications in this case. (2) gave evidence that the IV vancomycin infusion was stopped early and before it had been fully administered. My concern is that both witnesses said that this fact would not be routinely documented in the drug administration records, and may not be recorded at all. There was no record in this case that the infusion was stopped early. The evidence at the inquest was that Ms Tompkins' death was not caused by either of these matters. However, I am concerned that any repetition would cause a risk in other cases.
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 25 June 2014. 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: via his solicitors Irwin Mitchell LLP. 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	**28 April 2014** **Philip Barlow**

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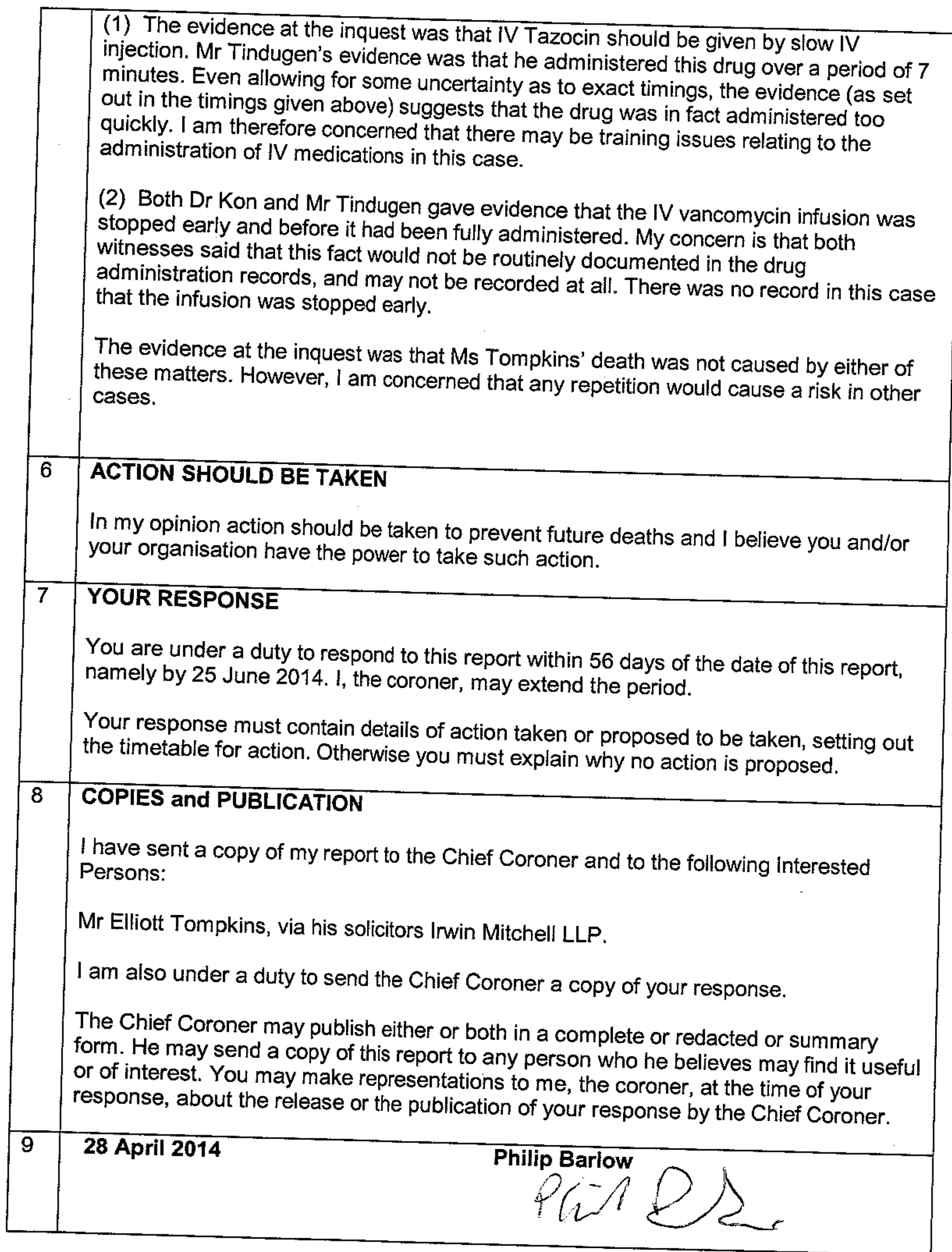
4	**CIRCUMSTANCES OF THE DEATH** Ms Tompkins had focal segmental glomerulosclerosis and was undergoing dialysis while awaiting a kidney transplant. On 6 July 2011 she was admitted to KCH under the care of Dr Kon. A CT scan suggested that Ms Tompkins had an infected pelvic fluid collection for which she was prescribed IV vancomycin and Tazocin, along with cyclizine. These drugs were administered by staff nurse Raul Tindugan. The vancomycin infusion was commenced at 20.07 and the IV cyclizine was given at 20.55 followed by the IV Tazocin. After receiving the Tazocin Ms Tompkins suffered allergic anaphylaxis. The cardiac arrest team were called at 21.00 and arrived at 21.04. Sadly, resuscitation attempts were unsuccessful. During the inquest I heard from several witnesses including Dr Kon, Mr Tindugen and expert evidence from Dr Peter Jackson, reader in clinical pharmacology at Royal Hallamshire Hospital, Sheffield.
5	**<u>CORONER'S CONCERNS</u>** 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 evidence at the inquest was that IV Tazocin should be given by slow IV injection. Mr Tindugen's evidence was that he administered this drug over a period of 7 minutes. Even allowing for some uncertainty as to exact timings, the evidence (as set out in the timings given above) suggests that the drug was in fact administered too quickly. I am therefore concerned that there may be training issues relating to the administration of IV medications in this case. (2) Both Dr Kon and Mr Tindugen gave evidence that the IV vancomycin infusion was stopped early and before it had been fully administered. My concern is that both witnesses said that this fact would not be routinely documented in the drug administration records, and may not be recorded at all. There was no record in this case that the infusion was stopped early. The evidence at the inquest was that Ms Tompkins' death was not caused by either of these matters. However, I am concerned that any repetition would cause a risk in other cases.
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8	**COPIES and PUBLICATION** I have sent a copy of my report to the Chief Coroner and to the following Interested Persons: Mr Elliott Tompkins, via his solicitors Irwin Mitchell LLP. 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	**28 April 2014** **Philip Barlow**