


ANNEX A

REGULATION 28: REPORT TO PREVENT FUTURE DEATHS (1)

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

	<p>REGULATION 28 REPORT TO PREVENT FUTURE DEATHS</p> <p>THIS REPORT IS BEING SENT TO:</p> <p>Mrs U. Ward Chief Executive Portsmouth Hospitals NHS Trust Queen Alexandra Hospital Southwick Hill Road Cosham PO6 3LY</p>
1	<p>CORONER</p> <p>I am David Clark Horsley, senior coroner, for the coroner area of Portsmouth and South East Hampshire.</p>
2	<p>CORONER'S LEGAL POWERS</p> <p>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.</p>
3	<p>INVESTIGATION and INQUEST</p> <p>On 22nd May 2013 I commenced an investigation into the death of Brenda Sillence, aged 77. The investigation concluded at the end of the inquest on 16th July 2015. The conclusion of the inquest was:</p> <ul style="list-style-type: none">- Coroner's Conclusion: Death due to an Accident.- Medical Cause of Death:<ul style="list-style-type: none">Ia: Multiple Organ FailureIb: Acute Generalised Exanthematous Pustulosis Secondary to PenicillinIc: CellulitisII: Morbid Obesity, Type 2 Diabetes Mellitus, Ischaemic Heart Disease, Chronic Obstructive Pulmonary Disease, Pneumonia.
4	<p>CIRCUMSTANCES OF THE DEATH</p> <p>Brenda Sillence died at Queen Alexandra Hospital on 17th May 2013 as a consequence of being prescribed Penicillin to which she had a fatal reaction.</p>
5	<p>CORONER'S CONCERNS</p> <p>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.</p> <p>The MATTERS OF CONCERN are as follows. –</p> <ol style="list-style-type: none">1) The section providing information about patient drug allergies and reactions is not easily located on the electronic discharge summary form being introduced by Queen Alexandra Hospital and I heard evidence that it should have a more

	<p>prominent and discrete location on the form. I share this view.</p> <p>2) Manual discharge summary forms will still be used in certain situations following introduction of the electronic form. The form intended to be used is in the same format as the form used on Mrs Sillence's discharge from hospital in 2010. I heard evidence about its lack of fitness for purpose and consider that it needs to be redesigned to make it more user friendly for both the clinician completing it and the recipients of the form. In particular, the lack of a prominent and separate section on the form for patient drug allergies and reactions needs to be addressed.</p> <p>3) The present Queen Alexandra Hospital procedure on a patient's discharge is to warn them orally about drug allergies and reactions, and to provide them with a copy of the discharge summary form. This form is couched in medical language and, in my view, the patient should also be given a separate written document giving information in plain language about drug allergies and reactions and this document should also be copied to the patient's general practitioner.</p>
6	<p>ACTION SHOULD BE TAKEN</p> <p>In my opinion action should be taken to prevent future deaths and I believe your organisation has the power to take such action.</p>
7	<p>YOUR RESPONSE</p> <p>You are under a duty to respond to this report within 56 days of the date of this report, namely by 21st September 2015. I, the coroner, may extend the period.</p> <p>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.</p>
8	<p>COPIES and PUBLICATION</p> <p>I have sent a copy of my report to the Chief Coroner and to the following Interested Person: [REDACTED]</p> <p>I am also under a duty to send the Chief Coroner a copy of your response.</p> <p>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.</p>
9	<p>27th July 2015</p> <p style="text-align: center;">[SIGNED BY CORONER]</p> <div style="text-align: center;">  <p>David Clark Horsley</p> </div>