	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO:** **1. Practice Manager, Upwell Street Surgery** **2. Ms Kirsten Major, Chief Executive, Royal Hallamshire Hospital** **3. Chief, Executive, NHS Digital** **4. Chief Executive, Clinical Commissioning Group**
1	**CORONER** I am David Urpeth, assistant coroner, for the coroner area of South Yorkshire West
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 25.4.19, an investigation into the death of Sandra Dawne Scott was commenced. The investigation concluded at the end of the inquest on 5.4.19. The conclusion of the inquest was a narrative conclusion, copy attached.
4	**CIRCUMSTANCES OF THE DEATH** On the 18th April 2019 Royal Hallamshire Hospital prescribed Mrs Scott Trimethoprim for a urine infection. They also did a urine test. On the Same day her GP saw the results of an earlier urine test showing a urinary tract infection which would not be receptive to treatment with Trimethoprim. The GP therefore advised Mrs Scott that she would prescribe Amoxycillin. The GP issued the prescription electronically to be collected at a pharmacy nominated by Mrs Scott. The GP then amended the system a few minutes later so that future prescriptions would not automatically be sent to that chemist. Unbeknown to the GP, the change meant that the prescription issued would now not be available for download by the original pharmacy. The results of the hospital urine test were available on the 20th April 2019 but were not acted upon at this point. Mrs Scott was admitted to Royal Hallamshire Hospital with worsening symptoms on the 22nd April 2019. She was appropriately treated at this point. However, she deteriorated and sadly died on 23rd April 2019.
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. – During the inquest, evidence showed:- 1. The GP issued a prescription to a nominated chemist, but a few minutes later put the system details back to what they were before the prescription was issued. Unbeknown to the GP these changes meant the prescription was no longer available for download by the chemist. 2. This resulted in the patient not getting required medication. 3. The evidence was that the GPs colleagues were also unaware of this peculiarity of the system. 4. Other medical professionals are also likely to be unaware. 5. The Royal Hallamshire Hospital received the results of a urine test on the 20.4.19 but did not act upon them as the patient had been discharged. 6. The evidence was that had the patient received the medication prescribed by the GP or indicated by the hospital results, then she would not have died when she did. 7. There is the potential for wide learning from this tragic case.
6	**ACTION SHOULD BE TAKEN** In my opinion action should be taken to prevent future deaths and I believe you 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 2nd January 2020. 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 to all Interested Persons :- The family of Mrs Scott, the deceased. 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	**6.11.19** ***David Urpeth*** ***Assistant Coroner***