M. E. Voisin
Her Majesty's Senior Coroner
Area of Avon

19th September 2023 [redacted]

	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO:** [redacted] **Deputy Director of Patient Safety, Digital at the NHS** [redacted] [redacted]**, North Bristol NHS Trust.**
1	**CORONER** I am Dr Simon Fox KC, Assistant Coroner for **Area of Avon.**
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 10th March 2023 I commenced an investigation into the death of Stephen William Cassidy. The investigation concluded at an inquest on 18th September 2023. The conclusion of the inquest was – ***"Mr Cassidy died from a known drug allergy because its existence was not obtained by hospital medical staff from his Summary Care Record."***
4	**CIRCUMSTANCES OF THE DEATH** In 2018 Barnet Hospital in London found Mr Cassidy to be allergic to Ceftriaxone and recorded this fact in his Summary Care Record (an electronic patient record). Mr Cassidy appears to have been unaware of his allergy – probably because he experienced it during a period of encephalitis such that he had no clear memory of it. On 4th March 2023 Mr Cassidy fractured his hip and clinical staff from South Western Ambulance Service NHS Foundation Trust (SWAS) conveyed him by ambulance to Southmead Hospital, Bristol (SMH). SWAS staff were able to access the Summary Care Record, obtain the history of Ceftriaxone allergy and record this in their clinical record. On admission to SMH a copy of the SWAS clinical record was scanned into the SMH records and a member of SMH emergency department nursing staff noted the Ceftriaxone allergy, but it was not acted upon further. Mr Cassidy was listed for surgical repair of his fractured hip the following day.

	None of the doctors who assessed Mr Cassidy in the emergency department, the trauma and orthopaedics team or the anaesthetist at his operation were able to access the Summary Care Record to obtain the history of Ceftriaxone allergy and none of them were aware of it. On 5th March 2023 Mr Cassidy was administered intravenous Ceftriaxone as part of routine induction of anaesthesia for his hip surgery. He immediately suffered a severe anaphylactic reaction to the Ceftriaxone from which he died shortly afterwards despite appropriate and extensive attempts to resuscitate him. Despite the Ceftriaxone allergy being recorded on his Summary Care Record in 2018 and the potential fatal outcome of such a history being disregarded, the evidence at the Inquest demonstrated that – a) There was no provision for clinical staff at SMH to access patients' Summary Care Record routinely or easily; b) This was despite provision existing for SWAS clinical staff to do so before a patient arrived at hospital; c) There was no provision for the Summary Care Record to be integrated with SMH's hospital electronic patient record (known as Careflow/Connect) or the primary care electronic patient record (EMIS – Egton Medical Information System) – such that the Ceftriaxone allergy automatically appeared in SMH's electronic patient record; d) As a result none of the emergency department doctors, the trauma and orthopaedics team or the anaesthetist who administered the antibiotic with induction were able to ascertain Mr Cassidy's Ceftriaxone allergy; e) This led to an avoidable fatal anaphylactic reaction.
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. – a) There is no provision for clinical staff at SMH to access patients' Summary Care Record routinely or easily; b) This is despite provision existing for SWAS clinical staff to do so before a patient arrives at hospital; c) There is no provision for the Summary Care Record to be integrated with SMH's hospital electronic patient record (known as Careflow/Connect) or the primary care electronic patient record (known as EMIS – Egton Medical Information System) – such that the Ceftriaxone allergy automatically appears in SMH's electronic patient record; d) As a result hospital doctors are ignorant of important clinical information on the patients they are treating; e) This can lead to avoidable patient harm including death.

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 14th November 2023. 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 family. 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	19th September 2023  Signature Dr Simon Fox KC Assistant Coroner **Area of Avon**