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 of University Hospitals of Derby & Burton NHS Foundations Trust** **2 Minister of Health**
1	**CORONER** I am Andrew BARKLEY, H M Senior Coroner for the coroner area of Staffordshire and Stoke-on-Trent
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 14 June 2023 I commenced an investigation into the death of Glennis CONNELLY aged 87. The investigation concluded at the end of the inquest on 30 April 2024. The conclusion of the inquest was that of a narrative conclusion of drug related (prescription medication) contributed to by neglect.
4	**CIRCUMSTANCES OF THE DEATH** Glennis CONNELLY died on 11th November 2022 at her home address [redacted] Swadlincote Derbyshire . She died from the effects of end stage renal failure, due to tubulo interstitial nephritis which was caused by the prescription of tazocin, which she was prescribed on 14th Sept 2022. She had previously been prescribed tazocin, to treat her respiratory infections in October 2019 and January 2020 and was found to have an allergy to the drug which has caused tubulo interstitial nephritis. On each occasion she suffered an acute kidney injury which was successfully treated with steroids. Despite both instances being at the Queens Hospital Burton Upon Trent, the information relating to her allergy to tazocin was not recorded in hospital records held at Queens Hospital Burton Upon Trent, although it was available , and accessible through her Summary Care Records held by her General Practitioner and clinic letters, which were not accessed.
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: Although the Queens Hospital Burton Upon Trent and the the Royal Derby Hospital are governed by the same hospital trust, they have different electronic patient records. Entries made by the renal team at the Royal Derby Hospital are not automatically visible to medical staff at the Queens Hospital, "allergies" do not automatically cross populate despite entries being made on the Lorenzo system and the GP records being updated on 6th & 12th February 2020.

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 July 26, 2024. 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 **1 Queens Hospital Burton** **2 Family** 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: 31/05/2024**  **Andrew BARKLEY** **H M Senior Coroner for** **Staffordshire and Stoke-on-Trent**