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 Secretary of State for Health and Social Care** **2 Royal College of Radiologists** **3 MHRA: Medicines and Healthcare Products Regulatory Agency** **4 University Hospitals of Northamptonshire NHS Group**
1	**CORONER** I am Hassan SHAH, Assistant Coroner for the coroner area of Northamptonshire
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 20 February 2023 I commenced an investigation into the death of Dominic Martin PHILIP aged 75. The investigation concluded at the end of the inquest on 05 March 2025. The conclusion of the inquest was that: Mr Dominic Martin Philip died on 3rd February 2023 at Kettering General Hospital as a result of an anaphylaxic reaction to contrast medium injected for the purposes of an abdominal CT Scan. 1a – Acute anaphylaxis
4	**CIRCUMSTANCES OF THE DEATH** Mr Dominic Martin Philip died on 3rd February 2023 at Kettering General Hospital as a result of an anaphylaxic reaction to contrast medium injected for the purposes of an abdominal CT Scan in order to investigate/rule out a bowel obstruction.
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: (brief summary of matters of concern) a) It was stated in evidence that - an X-Ray is no longer preferred as it is not sensitive enough and a smaller obstruction might be missed; anaphylactic type reactions to iodinated contrast agents are rare accounting for 0.6% of cases with only 0.04% considered aggressive; and almost all contrast reactions that are life threatening occur within 20 minutes of intravenous injection. The current policy appears to be that a patient referred for a CT scan by the Emergency Department is to be accompanied by a doctor trained in advanced life support (ALS). In Mr Philip's case, he was accompanied by a Core Trainee Year 2 who had ALS training. The policy for planned/outpatient interventions was not fully explored at inquest, but there was a suggestion that there might be some possibility of

	testing for an allergic reaction to the contrast medium in advance of such an appointment? My concern is that if a patient has never before had contrast medium (as was the case with Mr Philip) they cannot possibly know if they have an allergy to it. Making arrangements for ALS after the event seems reactionary and I wondered if any other options might be available which would flag a potential allergy before the contrast is injected. b) Mr Philip did disclose an allergy to Lidocaine. The toxicology report records that Lidocaine was detected in Mr Philip's blood post-mortem. Despite the hospital conducting a comprehensive review of the care provided, it has not been possible to ascertain why Lidocaine was present in Mr Phillip's system. Aside from the contrast medium, the only medication that Mr Philip received at hospital was IV Tazocin, IV paracetamol, Oramorph and IV saline. The toxicologist has also ruled out any possibility of contamination of the blood sample during testing. The toxicologist adds "I note that Mr Philip is described as healthy so I would not expect its use outside a hospital setting". There was no other source identified at inquest. I am therefore concerned that Mr Philip has come into contact with Lidocaine without any explanation – could there be a contaminated supply of medication? Have there been any similar unexplained occurrences anywhere else in the country? This is of course of particular concern to those who, like Mr Philip, are allergic to Lidocaine. c) It has also been brought to my attention in a different case currently under investigation within my jurisdiction that as Lidocaine is a prescription only medication, it needs to be stored in a locked cupboard. However, Lidocaine is not a Controlled Drug which means that clinicians do not need a double signature to remove the medication from the stock and it is not subject to a count of the stock each time an ampoule is used. The Hospital has stated that "The use of Lidocaine will vary within each area dependant on the patients being seen within each department and treatments given. Stock levels are reviewed by pharmacy to ascertain stock required. Unless a large amount of stock was removed from a single clinical area there would be no alert to indicate that Lidocaine was being removed for reasons other than patient treatment".
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 May 09, 2025. 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 [redacted] I have also sent it to **University Hospitals of Northamptonshire NHS Group** who may find it useful or of interest. 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: 14/03/2025** [redacted] **Hassan SHAH** **Assistant Coroner for Northamptonshire**