REPORT TO PREVENT FUTURE DEATHS REGULATION 28 OF THE CORONERS (INVESTIGATIONS) REGULATIONS 2013	
1.	**CORONER** I am Miss Laurinda Bower, HM Area Coroner, for the coroner area of Nottingham City & Nottinghamshire.
2.	**DATE OF REPORT** 20 May 2026
3.	**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.
4.	**THIS REPORT IS BEING SENT TO** 1. The Medical Director, Nottingham University Hospitals NHS Trust 2. Nottingham and Nottinghamshire Integrated Care Board You are under a duty to respond to this report within 56 days of the date of this report, namely by July 16, 2026. I, the coroner, may extend the period if an appropriate application is made.
5.	**YOUR RESPONSE** 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. I have a duty to send a copy of your response to the Chief Coroner. In accordance with the Chief Coroner's Publication Policy, you should send me any representations regarding publication of your response. These representations should be made at the same time as the response is provided. I will pass any representations received to the Chief Coroner for a decision. Please note any links to webpages included in the response will not be checked for sensitive information prior to publication, as the information is already online. The names of those who do not respond to PFD reports are regularly published on the Chief Coroner's webpages Non-responses to Prevention of Future Death (PFD) reports - Courts and Tribunals Judiciary.
6.	**SUMMARY OF CORONER'S CONCERN** **1. (NUH) Failure to ensure an "*inquiring mind*" in satisfying the duty of candour** **2. (ICB) Roll out of the Penicillin Allery De-Labelling Pathway**

7.	**ACTION SHOULD BE TAKEN** In my opinion unless action is taken to address the above concerns then there is a significant risk of future deaths and I believe each of you have the power to take such action.
8.	**INVESTIGATION AND INQUEST** On 15 April 2025 I commenced an investigation into the death of Jennifer Susan BIRCH aged 27. The investigation concluded at the end of the inquest on 20 May 2026. The conclusion of the inquest was that: Jen died as a result of a rare anaphylactic response to teicoplanin.
9.	**CIRCUMSTANCES OF DEATH** Jennifer Susan Birch died on 11 April 2025, at the Queens Medical Centre, Nottingham, as a result of an hypoxic brain injury, sustained during a period of anaphylaxis in response to the administration of intravenous prophylactic antibiotic, teicoplanin, in the peri-operative period of an elective procedure performed on 8 April 2025. During the peri-operative anaesthetic emergency, a 2222 call was not put out, contrary to local guidance. While this probably led to some omissions in the care that could have been provided to Jen, it has not been possible to determine whether such omissions have more than minimally contributed to her death.
10.	**CORONER'S CONCERNS** During the course of the inquest I heard evidence 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: **1. (NUH) Failure to ensure an "*inquiring mind*" in satisfying the duty of candour** The Trust can only seek to learn lessons from events if it has, at every level, an inquiring mind that seeks to capture all relevant evidence at the earliest opportunity following clinical events. My investigation, and that of the PSII, was hampered by the failure of staff to complete a Datix report on the day of the event. This led to a failure to quarantine the medical equipment used in theatre (which was suspected of potential malfunction), a failure to download all accurate clinical data from the machines, and a failure to retain the second, retrospectively completed, anaesthetic chart. This is not an isolated incident, nor one that is unique to this Department. This is a Trust wide issue. Coronial investigations over recent years have been

	hampered in establishing the truth because of a failure by the Trust to retain relevant material post clinical events (placentas disposed of following neonatal harm – PFD report issued 2021, lost CTG traces, cardiology medical devices not being retained/quarantined/inspected in a timely fashion leading to relevant data being overwritten or devices destroyed – informal letter sent 2026). The Trust must ensure a culture that promotes a forensic inquiring mind, supported by robust systems to promptly identify and retain evidence, especially as a number of the medical devices used across the Trust are not networked or cloud based, meaning data can be lost when the device is switched off or memory is overwritten when the device is next used. **2. (ICB) Roll out of the Penicillin Allery De-Labelling Pathway** Teicoplanin carries a rare but recognised risk of severe anaphylaxis and reaction occurring in an estimated 0.1-1% of cases. Teicoplanin is often used as an alternative to penicillin for patients who report penicillin allergy. The risk of serious complications is greater in teicoplanin than many other forms of antibiotic (NAP6). It has been described as “an emerging problem in the anaesthetic allergy clinic” (British Journal of Anaesthesia, 2015). Jen was administered teicoplanin in the peri-operative period because the recommended antibiotic for her elective procedure, Flucloxacillin, is from the same antibiotic family as penicillin, and Jen’s medical records reported an allergy to penicillin in the form of a rash as a baby. The use of teicoplanin in this case was entirely appropriate given Jen’s allergy warning, but it did expose her to a risk of severe anaphylaxis, which materialised and caused her death. In the months following Jen’s death, some Trusts have rolled out an inpatient initiative to seek to de-label penicillin allergy from patient medical records where risk stratification determines that the patient does not have a true allergy to penicillin. The SPACE study established that up to 10% of the population carries documented penicillin allergy but over 90% of these are inaccurate. False labels have been shown to increase antibiotic resistance, higher surgical site infections, longer hospital stays, as well as exposing patients to unnecessary complications associated with second-line antibiotics. One local Trust, Doncaster and Bassetlaw NHS Trust, has already rolled out an inpatient PADL pathway. The SPACE study proved it is clinically safe and effective for non-allergy healthcare professionals to use approved risk stratification and direct oral penicillin challenges for low-risk patients, ensuring the burden for this pathway does not impact on the often-small secondary care allergy service. Does the ICB plan to commission this pathway across all local Trusts? At present, NUH does not offer this pathway.
11.	**COPIES AND PUBLICATION OF THIS REPORT**

	I have a duty to send a copy of my report to every Interested Person who in my opinion should receive it. I also may send a copy of the report to any other person who I believe may find it useful or of interest. I can confirm I have sent the report to: *[please do not use individual's names, but instead roles/titles]* • **Jen's Family** • **Nottingham University Hospitals NHS Trust** • **CQC** I also have a duty to send a copy of the report to the Chief Coroner. You may make representations to me, the coroner, about the publication of the contents of this report in line with Chief Coroner's PFD Publication Policy (2026). Any representations will be sent to the Chief Coroner alongside the report. Please refer to box 4 above for additional information relating to the publication of reports and responses.
12.	**SIGNATURE** **Miss Laurinda Bower** **HM Area Coroner** **Nottingham City and Nottinghamshire**