REGULATION 28: REPORT TO PREVENT FUTURE DEATHS(1)

	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS THIS REPORT IS BEING SENT TO: 1. [redacted] (CHIEF EXECUTIVE, QUEENS HOSPITAL).
1.	I am Chinyere Inyama, senior coroner for the coroner area of Eastern District Greater London.
2.	**CORONER'S LEGAL POWERS** I make this report under paragraph 7, Schedule 5, of the Coroner's and Justice Act 2009 and regulations 28 and 29 of the Coroners (Investigations) Regulations 2013.
3.	**INVESTIGATION and INQUEST** On 30th August 2012 I commenced an investigation into the death of Tripta Rani KUMAR,69 years. The investigation concluded at the end of the inquest on 4th September 2013. I concluded with the narrative "The deceased undertook routine, planned vaginal hysterectomy and anterior repair on 21st August 2012 before being discharged on 23rd August. She was readmitted on the 24th August 2012 with overwhelming sepsis as a result of bowel perforation likely incurred during the procedures carried out on 21st August. She died as a result." The medical cause of death was 1a. Multiple Organ Failure, 1b. Organising Peritonitis, 1c. Perforation of Large Bowel (repaired), II. Old Empyema of chest
4.	**CIRCUMSTANCES OF THE DEATH** 1. The deceased had a planned hysterectomy for a prolapse on Tuesday 21st August and was discharged on 23rd August 2012. 2. She was readmitted on the 24th August 2012 complaining of abdominal pain and found to have a perforated bowel. 3. Hartmans procedure completed but she was septic by this stage. Maximum treatment continued post operatively in ITU but she suffered a cardiac arrest on the 25th August 2012.

	4. CPR was given but she died despite efforts made.
5.	**CORONER'S CONCERNS** During the course of the inquest evidence revealed matters giving rise to concern. In my opinion there is 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:- In the emergency department, during the course of treatment given on the 24th August 2012, the deceased was attended to by an ST4, doctor in Obstetrics and Gynaecology. The doctor documented the likely diagnosis, requested an urgent CT scan and prescribed intravenous antibiotics in the form of Tazocin. Tazocin contains two active ingredients, Piperacillin, which is a penicillin type antibiotic and Tazobactum which is a medicine that prevents bacteria from inactivating Piperacillin. Evidence from the family of the deceased, confirmed by [redacted] (Consultant in Accident and Emergency), revealed that the notes clearly showed that the patient had a penicillin allergy. The family of the deceased also confirmed in court that their mother was wearing a band on her wrist which confirmed the penicillin allergy. [redacted] further confirmed that the entry in the notes that said 'penicillin allergy' had been crossed out and the note 'nil allergies' had been entered instead. This was in handwriting but with no signature to confirm who had written the note. The grave danger is that, although not relevant in this particular case, giving someone penicillin who was allergic to that penicillin could easily have resulted in anaphylactic shock which, in turn, could have resulted in death.
6.	**ACTION SHOULD BE TAKEN** In my opinion action should be taken to prevent future deaths and I believe you/or your organisation have the power to take such action. It is clear there should be a review of the systems in place that are meant to ensure there is no risk of anaphylactic shock in such cases. In addition, the operation of the system should be audited on a regular

	basis since potential consequences of absence of or poor operation of such systems are potentially so serious.
7.	You are under a duty to respond to this report within 56 days of the date of this report namely by 15th November 2013. 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] [redacted] and [redacted]. 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 of the publication of your response by the Chief Coroner.
9.	**19th September 2013.**