ANNEX A

REGULATION 28: REPORT TO PREVENT FUTURE DEATHS (1)

*NOTE: This form is to be used **after** an inquest.*

	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO:** 1. Cwm Taf University Morgannwg Health Board;
1	1. **CORONER** I am Dr. Sarah-Jane Richards, HM Assistant Coroner, for the Coroner area of South Wales Central.
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 12 April 2021, I commenced an investigation into the death of Mr. Donald Vernon Compton The investigation concluded at Inquest on 24 February 2022. The medical cause of death provided by consultant pathologist, Dr. [redacted], University Hospital of Wales was: 1a *Stevens-Johnson Syndrome/Toxic Epidermal Necrolysis AND Covid-19 infection in a man with dilated cardiomyopathy and chronic renal failure* The Coroner's narrative conclusion was: *Death of an 87 year old man with severe life threatening comorbidities who contracted Covid 19 and developed Stevens-Johnson Syndrome /Toxic Epidermal Necrolysis - the aetiology of which was likely an adverse reaction to an antibiotic to which there was a known allergy*.
4	**CIRCUMSTANCES OF THE DEATH** These were recorded as:- Donald Vernon Compton 87 years suffered a collapse at his home in Talbot Green, South Wales and was admitted to the Royal Glamorgan Hospital (RGH) on 1st January 2021. He was diagnosed as suffering tachycardia and severe left ventricular failure with paroxysmal atrial fibrillation, severe renal failure and previous stroke. Once stabilised, he was transferred to a residential care home in Torbay to be closer to his family. At some point he contracted Covid 19 and on 11 February 2021 was admitted to Torbay and South Devon Hospital suffering from Stevens-Johnson Syndrome/Toxic Epidermal Necrolysis - the likely aetiology being Co-trimoxazole, an antibiotic with the constituent drug trimethoprim to which Donald Compton had a known allergy. In spite of this allergy being known, Mr. Compton was prescribed Co-trimoxazole as a part of his discharge medications in error and which was also erroneously approved by the overseeing pharmacist and ward nurses.

	Mr. Compton lacked the reserve to combat the effects of Stevens-Johnson syndrome and Covid 19 and he passed away in the Torbay and South Devon Hospital on 14 February 2021. Of further significant concern was i) a previous medication error after Mr. Compton's admission to the Royal Glamorgan Hospital in respect to amiodarone although without obvious adverse effect; and ii) Mr. Compton's Torbay GP similarly prescribed Co-trimoxazole, even though the GP had been sent a discharge letter which clearly stated his patient's allergy to trimethoprim. Fortunately, Co-trimoxazole was not provided to him.
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 further 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:- <u>Prescribing and dispensing errors</u> 1. At the time, the All Wales electronic prescribing tool (eDAL) permitted prescribers to avoid reading the section concerning known allergies; 2. The commonly prescribed antibiotic Co-trimoxazole comprises two constituent drugs trimethoprim and sulfamethoxazole. Allergies were not noted as Co-trimoxazole but to the constituent drug, trimethoprim. 3. Prescribing hospital doctors; overseeing pharmacist; and ward nurses all failed to pick up on this discharge prescribing and dispensing error suggesting drug safety on discharge is an area for scrutiny and input to ensure a similar error is avoided a patient safety is maximised. 4. That the Torbay GP also made an error in prescribing Co-trimoxazole to Mr. Compton in the knowledge he was allergic to trimethoprim indicates the lack of specific knowledge about this antibiotic and its constituent elements. It may also reflect a more general lack of knowledge about constituent components of commonly prescribed drugs. 5. A different prescribing error was made in respect of this same patient whilst under the care of RGH. The down titration of Amiodarone was overlooked resulting in too high a dose being administered over several days.
6	**ACTION SHOULD BE TAKEN** In my opinion action should be taken to prevent future deaths and I believe you and your organisation have the power to take such action. • Pharmaceutical product allergies to be noted on patient records not only by the constituent drug name but also the name of the drug being prescribed in this case, the antibiotic Co-trimoxazole. • Prescriptions to be noted on medical records/patient notes and discharge letters by both their brand names and generic pharmaceutical names. • Prescriptions to be noted on medical records/patient notes and discharge letters by brand/generic name as well as constituent components e.g. Co-trimoxazole comprises <u>trimethoprim</u> and sulfamethoxazole. Mr. Compton's discharge letter states his allergy was to <u>trimethoprim</u>. • An inability to circumnavigate known allergy information by Users of the electronic prescribing tool (eDAL)

7	**YOUR RESPONSE** You are under a duty to respond to this report within 56 days of the date of this report, namely by 17 May 2022, allowing for statutory holidays. I may extend this period upon request. 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 Cwm Taf University Morgannwg Health Board, the Chief Coroner and [redacted] (son of the deceased). 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. 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 – 20 March 2022 **SIGNED:**  Dr. Sarah - Jane Richards, HM Assistant Coroner for South Wales Central