## Regulation 28: Prevention of Future Deaths report

Peter Carr (died 21/09/21)

	THIS REPORT IS BEING SENT TO: Department of Health and Social Care 39 Victoria Street London, SW1H 0EU
1	CORONER I am: Dr. P. H. Straker, Assistant Coroner for North London Barnet Coroner's Court 29 Wood Street, London EN5 4BE
2	CORONER'S LEGAL POWERS I make this report under the Coroners and Justice Act 2009, paragraph 7, Schedule 5, and The Coroners (Investigations) Regulations 2013, regulations 28 and 29.
3	<ul> <li>INVESTIGATION and INQUEST</li> <li>On 5<sup>th</sup> October 2021 I commenced an investigation into the death of Peter Carr. The investigation concluded at the end of the inquest held on the 9<sup>th</sup>,10<sup>th</sup> and 11<sup>th</sup> of October 2023.</li> <li>The conclusion of the inquest was a short narrative conclusion;</li> <li>Peter Carr died from a recognised complication of necessarily prescribed medication.</li> </ul>

## 4 CIRCUMSTANCES OF THE DEATH

On the 25th of August Mr. Carr developed a rash. By the 31st most of his skin was red so he presented to the North Middlesex Hospital A&E where he was admitted by the medical team. He also had neutropenia and lymphadenopathy. The admitting doctor prescribed tazocin, a rare side effect of which is Stephens-Johnson Syndrome (SJS) / Toxic Epidermal Necrolysis (TEN.) The North Middlesex outsources dermatology. Mr. Carr first saw a dermatologist 3 days after admission at which point there was no sign of SJS / TEN. Nevertheless skin biopsy - something every consultant dermatologist can do - was deemed necessary but the attendant dermatologist, who could have done this, did not becaue the company's process is to ask a plastic surgeon to biopsy. It took until the 8th for the biopsy to be taken. There was no dermatological oversight of Mr Carr's skin in the intervening time. The biopsy found evidence of drug reaction consistent with SJS. An optimum dermatology service was described by our expert as patients being seen by a consultant dermatologist and biopsied if required within 24 hours of presentation, and then watched like a hawk on a daily basis. Had this happened the emergence of SJS may have been recognised and prompted withdrawal of the culprit medication. That this level of dermatological support was not available denied Mr.

5 Carr 'a role of the dice' - a chance of survival.

## **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 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.

That patients who contact medical services with acute, severe, skin conditions as primary presentations, or as a component of a complex presentation, may not have consultant dermatology input and biopsy within 24 hours and ongoing consultant dermatology oversight for the duration of an inpatient stav.

6	ACTION SHOULD BE TAKEN
	In my opinion, action should be taken to prevent future deaths and I believe that your organisation has 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 29 <sup>th</sup> December 2023. 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 following.
	<ul> <li>The Family.</li> <li>Omnes Healthcare.</li> <li>The North Middlesex University Hospital.</li> <li>University College London Hospital.</li> </ul>
	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 or the publication of your response by the Chief Coroner.
9	13 <sup>th</sup> October 2023. Assistant Coroner. Dr. Peter Straker
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