



Department
of Health &
Social Care

*From The Rt Hon. Andrew Stephenson CBE MP
Minister of State for Health*

39 Victoria Street
London
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Dr. P. H. Straker
Assistant Coroner for North London
Barnet Coroner's Court
29 Wood Street
London
EN5 4BE

8 May 2024

Dear Mr Straker,

Thank you for your Regulation 28 report to prevent future deaths dated 13 October 2023 about the death of Peter Carr. I am replying as Minister with responsibility for medicines.

Firstly, I would like to say how saddened I was to read of the circumstances of Mr Carr's death and I offer my sincere condolences to his family and loved ones. The circumstances your report describes are concerning and I am grateful to you for bringing these matters to my attention. Please accept my sincere apologies for the delay in responding to this matter. I would like to assure you that the department is mindful of the statutory responsibilities in relation to prevention of future deaths reports and we are prioritising responses as a matter of urgency.

The report raises concerns, "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 stay".

In preparing this response, Departmental officials have made enquiries with NHS England, the Care Quality Commission (CQC), Medicines & Healthcare products Regulatory Agency (MHRA) and I share their findings and actions taken to address your concerns.

It is understood that Stevens-Johnson (SJS) syndrome is a recognised but rare complication following the administration of some medications, and patients often present in the emergency department and are cared for by admitting physicians. It requires rapid diagnosis and specialist referral for onward management of the condition. We enquired about the information provided with the medication from MHRA. They advise that the product information for Tazocin highlights the risk of severe cutaneous adverse reactions, including SJS and that patients developing skin

reactions should be closely monitored. There are warnings in the prescribing information and the patient leaflet which advises that patients should see a doctor immediately if they experience any of the listed potentially serious side effects of Tazocin.

I understand that there can be difficulties in the diagnosis and management of the patient pathway which is complex as it covers both a general and specialised pathway. The NHS England service specification for specialised dermatology highlights the importance of early referral to treat SJS and we recognise that a specialist service is required for this group of patients. NHS England are undertaking work to develop a pathway, and intends to undertake a provider selection exercise in due course.

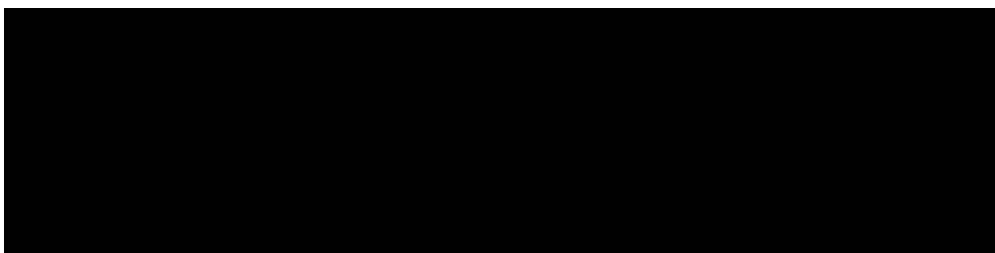
More locally, I understand that the Trust has improved the accessibility of Dermatology Services and introduced a new inpatient protocol agreed with the provider, Omnes, which ensures that inpatients requiring Dermatology review are seen within 1 working day. There is an escalation plan in place if reviews do not occur in line with agreed timescales. The Trust continues to monitor the provider for quality and performance against the protocol. They are also identifying opportunities to bring the outpatient service back onto the Trust site, which in turn will assist timely inpatient reviews. To ensure that key messages permeate down to staff at the workplace, the Trust is cascading the inpatient protocol via their Medical Director's bulletin, the induction pack for all medical staff and their internal intranet page. They have also updated the information on accessing Dermatology services both in and out of hours. Alongside this, sessions have also been set up to educate the staff on recognising early signs of emergency dermatological conditions, including SJS and Toxic Epidermal Necrolysis (TEN). Further, the Trust is exploring with Omnes, provision of a biopsy pack for dermatologists to undertake skin biopsies when required for inpatients.

It is equally important to apply learning and improvements to the wider system and I note that the Trust is conducting a review of all other services outsourced to third parties. Their aim is to ensure that the inpatient review process and accessing the out of hours service is clear. This information will be communicated to all staff who require it and be made available on the Trust intranet.

I realise that responses can form an important part of the process of family and friends coming to terms with what happened to their loved one and the recognition that steps have been taken to prevent it happening in the future. I have been informed that the Trust has also corresponded with the family around the steps taken to improve processes and embed the learning throughout their system.

I believe it is vital that we continue to improve patient outcomes and implement learning in the NHS which contributes to saving more lives. I have been assured that CQC contacted the Trust following this report and will continue to monitor the Trust to ensure safe standards of care are maintained through ongoing surveillance and engagement meetings.

I thank you once again for bringing these concerns to my attention.



THE RT HON ANDREW STEPHENSON CBE MP
MINISTER OF STATE