OFFICE OF THE
SENIOR CORONER
for the County of West Yorkshire
(Eastern District)

His Majesty's Coroner's Office
The Coroner's Courts
Burgage Square
Wakefield WF1 2TS

Telephone: [redacted]
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REGULATION 28: REPORT TO PREVENT FUTURE DEATHS

	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO:** **1. Midway Pharmacy, 46 Chapeltown, Pudsey, LS28 8BL** **2. General Pharmaceutical Council, Level 14, One Cabot Square, Canary Wharf, London, E14 4QJ**
1	**CORONER** I am Kevin McLoughlin, Senior Coroner for the Coroner area of West Yorkshire (Eastern).
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 23rd December 2024 I commenced an investigation into the death of David Joseph Crompton, aged 44. The investigation concluded at the end of the Inquest on 31st December 2024. The conclusion of the Inquest was a Narrative Conclusion based on the following cause of death: 1(a) Hypoxic ischaemic encephalopathy 1(b) Out of Hospital Cardiac Arrest 1(c) Cervical Spine Injury secondary to fall (2) Epilepsy This was resulting from a fall downstairs on 13th December 2024.
4	**CIRCUMSTANCES OF THE DEATH** Mr Crompton had epilepsy and was prescribed, inter alia, the anti-epileptic medication Tegretol. In April 2024 he was left without the medication for approximately 10 days as the pharmacy could not supply it. In December 2024 he was again left without the Tegretol. The pharmacy had left a manuscript "IOU" in relation to Tegretol at his home when other medicines were delivered. Without his medication his epileptic condition was likely to destabilise and give rise to fits. His falls both in April and December 2024 occurred when he was left without his essential medication.
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 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. – (1) It is important that when anti-epileptic medication is prescribed by a GP that this is obtained and supplied promptly by the dispensing pharmacy. It is a matter of concern that for relatively lengthy periods on two occasions Mr Crompton was left without this important medication. (2) The evidence given by family members at the inquest was that when the pharmacy was unable to supply the prescribed Tegretol medication, it was left to them to contact other pharmacies to see if they could obtain it, rather than for the pharmacy to search for supplies. (3) The inquest was informed that following the April 2024 episode, hospital specialists commented that the absence of Tegretol for around 10 days "will likely have contributed to your seizure activity". It is questionable whether lessons were learnt from this potentially dangerous interval. (4) Comment was made at the inquest to the effect that the pharmaceutical profession should have clear designated systems to deal with any shortages of supply encountered; for example, reference to hospital departments to ensure patients are not left without important medications. Leaflets explaining the role of those concerned in this situation were not provided.
6	**ACTION SHOULD BE TAKEN** In my opinion action should be taken to prevent future deaths and I believe your organisation have 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 27th February 2025 (to take account of the current holiday period). 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] (mother) [redacted] [redacted] (GP), Robin Lane Surgery, Robin Lane, Pudsey, Leeds, LS28 7DE 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	Signed: Kevin McLoughlin KEVIN McLOUGHLIN Senior Coroner West Yorkshire (E) Date: 31 December 2024