HEATH WESTERMAN
H.M. ASSISTANT CORONER

FOR SHROPSHIRE,
TELFORD & WREKIN AREA

H.M. Coroner's Service
Guildhall
Frankwell Quay
Shrewsbury
Shropshire SY3 8HB

Coroner's Office: [redacted]
Email: [redacted]

	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO:** 1. NHS England, Wellington House, 133-155 Waterloo Rd, London SE1 8UG Email: [redacted] 2. [redacted], Chief Executive of Shrewsbury and Telford NHS Trust
1	**CORONER** I am Heath Westerman, H.M. Assistant Coroner, for the coroner area of Shropshire, Telford & Wrekin.
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 July 2023 Mr Ellery, H.M. Senior Coroner for Shropshire, Telford & Wrekin commenced an investigation into the death of William Stephen GREEN The investigation concluded at the end of the inquest on 27 February 2025 The conclusion of the inquest was: William Stephen Green died on 9 July 2023 at The Royal Shrewsbury Hospital, Mytton Oak Road, Shrewsbury, Shropshire. He died as the result of toxic epidermal necrolysis secondary to Lamotrigine. This is a rare but recognised complication arising from taking Lamotrigine which was prescribed to Mr Green for the required treatment of his then known symptoms from 5 June 2023 until its cessation on or around 8 July 2023. Those complications, however, were not counselled or alerted to Mr Green upon his discharge from the hospital on 7 June 2023, nor was he advised on what to look out for and what to do in such circumstances. His death was contributed to by alcohol dependent disease.
4	**CIRCUMSTANCES OF THE DEATH** Mr Green was admitted to The Royal Shrewsbury Hospital, Mytton Oak Road, Shrewsbury, Shropshire on 5 June 2023 following a seizure probably alcohol related. He was started on Lamotrigine an anti-epileptic at a dose of 25mg once daily. He was discharged on 7 June 2023 with a pack of 56 Lamotrigine tablets at a dose of 25mg to be taken one daily. His compliance with taking the Lamotrigine once in the community is not known. He was re-admitted to The Royal Shrewbury

	Hospital on 5 July 2023 following a collapse and with a rash on his chest, back and upper limbs. He was treated for sepsis secondary to viral meningitis. A treatment plan was followed which included Lamotrigine to be administered once daily at the rate of 25mg. His condition deteriorated and on 8 July 2023 he was diagnosed with Steven Johnstone Syndrome. He died on 9 July 2023 as the result of toxic epidermal necrolysis secondary to Lamotrigine. Contributing to his death was alcohol dependent disease.
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) Once any patient at The Royal Shrewsbury Hospital is initiated on a new prescribed drug during an admission, no written record is ever made anywhere by anyone including pharmacy; nurses; doctors or consultants explaining or counselling the patient upon the possible side-effects or complications as a result of taking a specific prescribed drug; nor is there any written record on what to look out for and what to do in such circumstances and where they can get assistance. (2) No provision seems to be in place to record what should happen when the patient lacks capacity to understand such an explanation even when it is offered.
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.
7	**YOUR RESPONSE** You are under a duty to respond to this report within 56 days of the date of this report, namely by 25 April 2025. 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]. I have also sent a copy to [redacted] from the Trust. 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	 Heath Westerman H.M. Assistant Coroner Shropshire, Telford & Wrekin 28 February 2025

Send to: [redacted]