The Royal Wolverhampton
NHS Trust

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Mrs Joanne Lees
Area Coroner for The Black Country

E-mail: secure_coroners@sandwell.gov.uk

24th September 2025

Dear Coroner Lees

Re: In the matter of Regulation 28, Prevention of Future Death Report – Margaret Ann McNaughton - response due by 26th September 2025

Following the inquest on 22/07/2025, we have summarised the concerns you raised in relation to this Trust under the following headings:

1. Trust Policy does not provide guidance on HOW a patients allergy status should be checked or recorded and by whom and where - over and above a prescriber's professional responsibility and accountability.

2. Learning shared after the incident in an email to clinicians and a 'message of the week' does not go far enough in terms of ensuring the Trusts own recognition of 'lessons learned' have been embedded across the Trust.

3. I have not been reassured by the Trust that they followed their own policy in terms of how this medication error was dealt with at the time and therefore I am concerned that this presents a risk to patient safety at this time.

This letter sets out the Trust's response to the Regulation 28 notice received on 4th August 2025.

For context:

The inquest into the death of Mrs McNaughton found the cause of death to be respiratory failure due to COPD and cardiac arrest due to penicillin anaphylaxis. The inquest found no evidence that an allergy check was undertaken by the prescribing clinician who had not reviewed or spoken to Mrs McNaughton. There was no record that the clinician had accessed hospital records to determine prior allergy status.

The Trust acknowledges that control measures in place at the time of the incident were not fully effective as some of these measures were not available in the Emergency Department when the incident occurred.

Control measures:

- Medicine policies: MP01 Prescribing, Storage and Administration of Drugs, MP03 Medicines Reconciliation, MP05 Antimicrobial Policy.
- The Trust Patient Identification Policy (OP52) recommends the use of Red Allergy Wristbands to alert all practitioners and clinicians of known or suspected allergies.
- Electronic Prescribing and Administration (ePMA) system (awaiting implementation in the Emergency Department):
    - ePMA will not allow clinicians to prescribe unless the allergy box is completed.
    - ePMA will not let clinicians prescribe a drug if the patient is documented as having a severe allergy to that drug.
    - ePMA provides a warning before prescribing if the allergy is mild or moderate.
- The clinical ward pharmacy service undertakes medicines reconciliation on admission and ongoing review of in-patient prescription charts which includes allergy status checks (no clinical pharmacy service in the Emergency Department at the time of the incident)
- Training:
    - Prescribers must complete ePMA training before they are given access to ePMA.
    - Allergy checking is included in nurse medicines administration training.
- Governance:
    - The Trust Medicines Safety Group provides oversight of all harm incidents where 'medication incident' is identified on Datix to support learning and improvement.

Addressing the concerns that you have presented specifically to the Trust.

1. **Trust Policy do not provide guidance on HOW a patients allergy status should be checked or recorded and by whom and where - over and above a prescriber's professional responsibility and accountability.**

    - The Trust acknowledges that clear guidance on 'how' allergy status should be checked and recorded, by 'who' and 'where' is necessary for prescribing clinicians and recognises it as a gap in its current process.
    - A Short Working Life Group was set up with the specific remit for identification and recording of drug allergies. The group had representation from the multi-professional team and was led by the Chief Pharmacist. The group reviewed the current practice, including how Trust IT systems interact to inform the process for checking and recording drug allergies.
    - The 'HOW to' guide developed by the group is being incorporated into trust policy. The policy will state that 'medicines must not be prescribed or

administered unless allergy status information is completed' as an additional control measure.
Documentation: a review of paper prescription charts (where ePMA is unavailable) is underway which will improve the recording of a patients allergy status and will include space to record the information sources checked.

2. Learning shared after the incident in an email to clinicians and a 'message of the week' does not go far enough in terms of ensuring the Trusts own recognition of 'lessons learned' has been embedded across the Trust.

- Learning from the incident including the 'HOW to' guidance on drug allergy will be shared through Trust-wide communications on a number of platforms and details are included in the action plan.
- Emergency Department specific interventions:
  - A new Emergency Department Pharmacist post has been recruited to, and part of their role will be to ensure allergies are being documented and to provide training to clinical staff.
  - The Trust is progressing the introduction of ePMA in the Emergency Department once the new EPR (Electronic Patient Record) has been rolled out.

- Training: A bitesize training video is to be developed and made available to all clinical staff. The Trusts antimicrobial prescribing mandatory training is being updated to incorporate guidance on drug allergy.
- Monitoring: A Trust-wide audit of allergy recording on paper prescription charts has been completed to provide assurance and identify any gaps. This will be repeated on a regular basis and will have oversight from the Trust Medicines Safety Group.

3. I have not been reassured by the Trust that they followed their own policy in terms of how this medication error was dealt with at the time and therefore I am concerned that this presents a risk to patient safety at this time.

- The clinician involved in the incident was a temporary staff member (locum). Following the incident, the Clinical Director for the Emergency Department provided feedback to the clinician involved. If the clinician had stayed in the Trust they would have been required to reflect on the incident during their medical appraisal. However, the clinician left the organisation soon after the incident and is no longer working in the NHS; hence they are not connected to a Responsible Officer to provide feedback.
- For temporary staff the Trust has a process that provides induction and training which includes ePMA training for those who require access to the system, and the requirement to complete mandatory antimicrobial training for staff who will be in post for 3 months or more. The induction document for temporary staff will be updated to include specific reference to the Trust medicines policies, ePMA training and mandatory antimicrobial training.
- The Trust has an established process for managing medication errors that includes feedback to the relevant clinician and their line manager/educational supervisor to facilitate reflection and learning. The policy is being updated to align with PSIRF framework and the Trust is committed to system-based learning incorporating the principles of just culture to approach safety and accountability in the organisation.

Action Plan:

The plan and timescales for what is reasonably practicable is set out below. Implementation of the actions will be monitored through the existing Trust governance process.

Yours sincerely

Kevin Bostock
Group Director of Assurance