REGULATION 28: REPORT TO PREVENT FUTURE DEATHS (1)

	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO:** **1. The Royal Wolverhampton NHS Trust**
1	**CORONER** I am Mrs Joanne Lees Area Coroner for the coroner area of The Black Country.
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. https://www.legislation.gov.uk/ukpga/2009/25/schedule/5 https://www.legislation.gov.uk/uksi/2013/1629/part/7
3	**INVESTIGATION and INQUEST** On 19/12/24 I commenced an investigation into the death of **Margaret Ann MCNAUGHTON**. The investigation concluded at the end of the inquest on 22/7/25. The medical cause of Mrs McNaughton's death was found at inquest as; 1a. Respiratory failure due to chronic obstructive pulmonary disease 2. Cardiac Arrest due to Penicillin anaphylaxis The inquest concluded with a narrative conclusion and an addendum that the death of Mrs McNaughton was contributed to by Neglect.
4	**CIRCUMSTANCES OF THE DEATH** On 2/12/24 Mrs Margaret MCNAUGHTON was admitted to New Cross Hospital, Wolverhampton with breathing difficulties and was diagnosed with a respiratory infection. She had a known background of COPD. Hospital records from her admission recorded that Mrs McNaughton had no known drug allergies (NKDA) but it was unclear where this information had originated from. The EPR showed NKDA and Mrs McNaughton was reported to have denied any drug allergies when asked by paramedics. It was unclear if the EPR was available in the Emergency Department at the time the records were completed. The triaging Nurse had recorded Mrs McNaughton had NKDA and that Mrs McNaughton denied any drug allergies when asked. Mrs McNaughton did in fact have an allergy to Penicillin. At 2.18 pm on 2/12/24 *BEFORE* Mrs McNaughton was seen by any clinician she was prescribed I/V co-amoxiclav which is a penicillin based antibiotic. There was no evidence of any allergy checks having been made by the prescribing clinician as to Mrs McNaughton's allergy status. The prescribing clinician had not seen or spoken to Mrs McNaughton themselves. There was no evidence that the prescribing clinician had established the source of entries in the hospital records or accessed the hospital Clinical Web Portal. I found that this was a Gross Failure. The hospital Clinical Web Portal clearly recorded Mrs McNaughton as being allergic to Penicillin with an entry

to this effect clearly recorded in May 2023. In addition, by accessing the Clinical Web Portal the GP records for the deceased were also available which if accessed would have shown a recorded allergy to Penicillin in September 2024. Had the Clinical Web portal been accessed and allergy checks undertaken, then this information would have been known and McNaughton would not have been prescribed penicillin.

Within 25 minutes of the co-amoxiclav being administered intravenously Mrs McNaughton suffered a cardiac arrest due to penicillin anaphylaxis. She was resuscitated after 4 cycles of CPR and transferred to a ward where she sadly deteriorated with respiratory failure and passed away in hospital on 13/12/24.

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 could 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. Allery status checks are both important and essential. At inquest I heard that after the death of Mrs McNaughton there had been other ***'adverse incidents due to ignoring/not checking allergy status'***. This wording is taken from an email which was disclosed to me by the Hospital Trust as part of their learning and was sent by the Clinical Director to all clinicians on 13/4/25. The email goes on to state that no medication will be given without documentation of allergy status by a prescriber and that this must be checked on CWP +/- GP record and corroborated with the patient if they have capacity.
2. I was also informed at inquest that this email had been preceded by a *'message of the week'* which required a number of actions (albeit it was unspecific as to whom should be carrying out these actions i.e. medical or clinical staff). This message required two sources to confirm the allergy status and for the source to be documented.
3. I was informed that there had been work undertaken at the Trust following an audit in February 2025 which concluded as follows; *In conclusion, there continues to be concern with regards to the checking and confirmation of allergy status and the documentation regarding this. The Directorate feel that immediate action is required to ensure there is a process in place to reduce the risk of medication allergy incidents occurring and improve patient safety.*
4. Although there was no PSIRF investigation carried out after Mrs McNaughton's death, there was an internal incident investigation which identified lessons learned as '***STATUS MUST BE CHECKED ON CLINICAL WEB PORTAL AND DOCUMENTED AS SUCH'.***
5. I am concerned that an email to clinicians and a 'message of the week' does not go far enough in terms of the ensuring the Trusts own recognition of 'lessons learned' has been embedded across the Trust and that the requirements to check a patient's allergy status and record the findings ***and*** has not been enshrined in any Trust Policy.
6. Given the findings of the Trust from February 2025 and the date of the email sent by the Clinical Director in April 2025, the inference is that such further incidents have taken place after the death of Mrs McNaughton and AFTER the message of the week and AFTER the February 2025 audits. Although there is evidence that auditing is taking place, given incidents are continuing to occur I am concerned this presents and continues to present a risk to patient safety at this time.
7. The Trusts Policy on Prescribing, storage and administration of drugs states; '*it is the responsibility of a registered medical or dental officer to prescribe for a patient It is the responsibility of the prescriber to take a medication history and complete the drug allergy box*'. Again, whilst accepting this I cannot see anything in this policy that addresses my concern as to HOW this is carried out.
8. The Trusts Policy on Electronic Prescribing and Medicines Administration (ePMA) Policy outlines how the ePMA system must be used within the Trust. It provides an electronic system for prescribing, clinical checking, supplying, and administering medication. The Policy states that the system must enable the Trust to reduce the risk of medication errors and that the ePMA system also provides a Decision Support System (DSS) to ***aid safer prescribing and administration***. The Policy states *'Prescribers are responsible for entering allergy details into the patient's medical record within ePMA as part of their clerking, and thereafter regularly reviewing the allergy details.* Again, whilst accepting this I cannot see in this policy anything specific about HOW such checks should be carried out and

	when. *9.* The Trusts Management of Medication Errors Policy states*; it is the responsibility of a registered medical [or dental officer] to prescribe for a patient. It is the responsibility of the prescriber to take a medication history and complete the drug allergy box'* again accepting this, the policy otherwise deals with how errors are reported and dealt with, and does not appear to cover my concerns outlined above. *10.* I cannot see any Trust Policy that provides guidance on HOW a patients allergy status should be checked or recorded and by whom and where - over and above a prescribers professional responsibility and accountability. *11.* I am concerned that it remains unclear as to how such checks should be carried out (e.g use of CWP; two sources, timing of the recording of information etc..) and where information about such checks should be recorded. I am concerned this presents a risk to patient safety at this time. *12.* I am also concerned that there is no apparent requirement for a prescriber to record that they have either checked the patient's allergy status themselves before prescribing OR checked the source of the information contained within the hospital records. I am concerned this presents a risk to patient safety at this time. *13.* After reviewing the Policies provided to me, I also noted in The Trusts Management of Medication Errors Policy it defines level 1 and level 2 errors. I do not know what Level the incident concerning Mrs McNaughton was graded as but a level 2 error includes *'Errors resulting in actual patient harm i.e. any physical effect to a patient that is directly a result of a medication error'*. The incident report that I have been provided with only refers to an 'amber' incident. I understand the prescriber concerned in this case was a locum doctor and the policy states*; In the event of a locum doctor making an error the WMI will forward the report to both HR and the clinical lead for the doctor's specialty*'. The Policy also states *'The doctor will be counselled by their educational supervisor or clinical lead at the time of the incident who will require them to reflect on their practice. Suspension of a doctor from prescribing or administration of medicines will only occur if the doctor, their educational supervisor or clinical lead assesses that patients will be put at risk if the individual continues to prescribe. If necessary any further training will be arranged through the relevant clinical supervisor or clinical lead'.* *14.* I was not provided with a statement from the prescribing clinician involved in the incident referred to here although I was informed that the locum Doctor concerned had left the Trust. 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.
6	**ACTION SHOULD BE TAKEN** In my opinion action should be taken to prevent future deaths and I believe you and your organisation/s 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 26/9/25. 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 am also under a duty to send a copy of your response to the Chief Coroner and all interested persons who in my opinion should receive it.

	I may also send a copy of your response to any other person who I believe may find it useful or of interest. The Chief Coroner may publish either or both in a complete or redacted or summary form. She may send a copy of this report to any person who she 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.
9	**1/08/2025**