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02 March 2020

M.E. Hassell
Senior Coroner
Inner North London
St Pancras Coroner's Court
Camley Street
London N1C 4PP

Our ref: EH-304794

Dear Ms Hassell,

I write in response to your correspondence, dated 28 January 2020, regarding the death of Shanté Andreé Marie TURAY-THOMAS. I was very sorry to read of Ms Turay-Thomas' death.

We have considered the circumstances surrounding Ms Turay-Thomas' death, and the concerns raised in your report. In particular, the concerns that there is an absence of NICE guidance concerning:

- the dose of adrenaline in different adrenaline auto-injectors pens,
- the number of pens that should be carried, and
- training in how to use the devices

We note that you say in point 10 of your report that *'the whole area would benefit from NICE review'*.

Having reviewed your concerns, we consider that the British National Formulary (BNF) and the BNF for Children (BNFc) already contain detailed advice on these aspects of care, including the following pieces of MHRA/CHM advice from 2017 and 2019, in the section on Adreneline/Epinephrine (https://bnf.nice.org.uk/drug/adrenalineepinephrine.html) :

'***Adrenaline auto-injectors: updated advice after European review (August 2017)***

With intramuscular use

Following a European review of all adrenaline auto-injectors approved in the EU, the MHRA recommend that 2 adrenaline auto-injectors are prescribed, which patients should carry at all times. This is particularly important for patients with allergic asthma, who are at increased risk of a severe anaphylactic reaction. Patients with allergies and their carers should be trained to use the particular auto-injector they have been prescribed and encouraged to practise using a trainer device. Patients are advised to check the expiry date of the adrenaline auto-injectors and obtain replacements before they expire.

'Adrenaline auto-injectors: recent action taken to support safety (October 2019)

With intramuscular use

Healthcare professionals are reminded to follow existing advice on the use of adrenaline auto-injectors—see also Prescribing and dispensing information. Patients should be encouraged to read the MHRA advice sheet and to sign up for the Expiry alert service of their auto-injector device on the manufacturer's website.
Healthcare professionals should also be aware of recent alerts and letters issued about adrenaline auto-injectors including the activation failure issue with Emerade® auto-injector pens and the four-month extension of expiry dates of certain batches of Epipen® and Jext®. The MHRA has produced a letter on the Emerade® activation issue, which should be provided to patients and their carers.'

The BNF and BNFc are both joint publications of the British Medical Association and the Royal Pharmaceutical Society, and both formularies are accessible from the NICE website. Prescribers are expected to refer to information within the BNF and the BNFc to help inform prescribing decisions made with individual patients and carers. This expectation is set out in the General Medical Council's publication on 'Good practice in prescribing and managing medicines and devices', within the section titled: Keeping up to date and prescribing safely.

We have published a clinical guideline on food allergy in under 19s: assessment and diagnosis (CG116), which we understand would have been relevant to Ms Turay-Thomas' assessment and diagnosis. However, it does not cover the management of anaphylactic reactions and we therefore consider it not directly relevant to the concerns regarding her death.

We have also published a clinical guideline on anaphylaxis: assessment and referral after emergency treatment (CG134) and we have a quality standard on anaphylaxis (QS119). Both this guideline and quality standard cover care *after* emergency treatment for suspected anaphylaxis, including assessment and referral to specialist allergy services. That is, they begin at the point in the clinical pathway immediately *after* a health professional has started to manage a suspected anaphylactic reaction.

It is not clear from your report whether Ms Turay-Thomas had ever experienced an anaphylactic reaction *before* the one that caused her death, and it appears that she had died by the time any health professional attended her during the fatal episode. It is therefore unclear whether either CG134 or QS119 would have been directly relevant to the issues that contributed to her death.

We do not consider it appropriate for us to duplicate the BNF advice referred to above. However, we will consider how best to make clear in CG134 the advice that 2 adrenaline auto-injectors should be prescribed, which patients should carry at all times.

Yours sincerely,

[redacted]

Sir Andrew Dillon
Chief Executive