REGULATION 28: REPORT TO PREVENT FUTURE DEATHS (1)

*NOTE: This form is to be used **after** an inquest.*

	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO:** **1. General Pharmaceutical Council** **2. Secretary of State for Health** **3. Royal Pharmaceutical Society of Great Britain** **4. NHS England**
1	**CORONER** I am William Donald Forbes Coverdale, Senior Coroner for the Coroner area of York.
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 02.10.2009 I commenced an investigation into the death of Judith Lesley Marshall.. The investigation concluded at the end of the inquest on 29.11.2013. The conclusion of the inquest was that Judith Lesley Marshall died from 1a Bronchopneumonia 1b The effects of Morphine I recorded a Conclusion of Accidental Death.
4	**CIRCUMSTANCES OF THE DEATH** On 28.09.2009 Mrs Marshall, aged 72 years, was correctly prescribed, by her GP, 10mg of Morphine Sulphate bd (*"Morphine Sulphate M/R Capsules 10mg BD SIXTY CAPSULES Quant: sixty (60) capsule").* On the same day [redacted] a pharmacist of Beecham's Pharmacy, Derwent Practice, Norton, Malton, North Yorkshire dispensed 60 capsules of Morphine Sulphate at 60mg strength and not 10mg as prescribed. The box of capsules carried numerous clear references to 60mg capsules. [redacted] a trainee dispensing technician checked the medication dispensed by [redacted] and confirmed it. Mrs Marshall took the capsules as dispensed to her, twice a day as prescribed (taking 120mg of Morphine per day rather than 20mg). She was found by her husband dead in her bed on the morning of 30.09.2009.
5	**<u>CORONER'S CONCERNS</u>** 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) The Pharmacy's Errors Book shows a number of drug errors (including higher or lower dose tablets and the wrong drugs) over a number of years. It is not clear whether and to what extent such internal records are policed. (2) Despite a system of checking by a colleague it is apparent that there can be a mistake in dispensing medication which in this case was a controlled opiate drug. The consequences were fatal. (3) It is not clear whether there is any software, obtainable from the Department of Health or elsewhere, that could read prescriptions and raise an alert if the label sought to be created or if the drug sought to be dispensed is wrong in identity or amount. This would be of particular significance when a high risk drug is dispensed or when a drug is dispensed in an unusual quantity, dosage or form. (4) Mandatory procedures requiring a 'read-back' of the drug, its dosage, its frequency of administration and its total quantity may prevent such dispensing errors. In so far as the error in this case can be attributable to 'Human Error' it is concluded that the dispensing pharmacist focused on the figure of 60 and incorrectly attributed that to the dosage as well as to the number of capsules. (5) A mandatory check, by a suitably qualified pharmacist or by a third party, at the end of the day after cashing up on the till, of records of each (prescription only) drug dispensed against the prescription would be a further precaution against a repetition of these circumstances. (6) There is evidently no central database of all prescription errors so there can be no central monitoring of such errors and no means of determining trends or particular repeat errors.
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 24.03.2014. 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] the husband of the deceased (through his solicitors Messrs Lupton Fawcett of Leeds) • [redacted] and [redacted] (through their solicitors Messrs dwf of Leeds. • [redacted] Counter Assistant at Beecham's Pharmacy (through her solicitors Messrs VHS Fletchers of Nottingham) I have also sent it to • North Yorkshire Police who may find it useful or of interest. 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	**DATED 27TH JANUARY 2014** **HM SENIOR CORONER, COUNTY OF YORK**