A R W Forrest LLM, FRCP, FRCPath
GMC Number: 1333523
Her Majesty's Senior Coroner for South Lincolnshire

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. Helen Gordon, Chief Executive, Royal Pharmaceutical Society, 66-68 East Smithfield, London E1W 2AW** **2. Matthew Isom, Chief Executive, Dispensing Doctors' Association, 54A Piercy End, Kirbymoorside, North Yorkshire, YO62 6DF**
1	**CORONER** I am **Murray J Spittal, Assistant Coroner** for the Coroner's area of South Lincolnshire.
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 **26th November 2015** I commenced an investigation into the death of **Derrick TWAITE**, age 86. The investigation has not concluded, but evidence has been disclosed that indicates a situation exists that should be brought to the attention of relevant practitioners.
4	**CIRCUMSTANCES OF THE DEATH** 1) Mr Twaite had his medicines dispensed in a multi compartment compliance aid. One of his medicines was Finasteride, which is presented in a multi tablet bubble pack. Finasteride tablets, in their bubble where snipped from the multi-dose pack and placed in the compartments of the compliance aid. Mr Twaite appears to have swallowed one Finasteride tablet, still in its sharp edged bubble

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	pack segment. This caused a gut perforation which led to his death.
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. That although this practice of snipping tablets from the unit dose packs, still in their bubble, and place them in the compartments of multi-dose compliance aids is contrary to the advice of the relevant professional bodies, it apparently still being done by dispensing pharmacists and dispensing general practices..
6	**ACTION SHOULD BE TAKEN** In my opinion action should be taken to prevent future deaths and I believe you and/or 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 **28th April 2016**. 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: 1) [redacted] Lincolnshire Police 2) [redacted], Inspector C.Q.C. 3) [redacted] Prescribing Advisor, Arden and Greater East Midlands

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	Commissioning Support Unit 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	**29th February 2016** **MJ Spittal**..... **Assistant Coroner for South Lincolnshire**

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