REGULATION 28: REPORT TO PREVENT FUTURE DEATHS

	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO:** 1. The General Pharmaceutical Council, 25, Canada Square, London, E14 5LQ. 2. Boots UK Ltd., Head Office, D90, 1, Thane Road, Nottingham, Nottinghamshire, NG2 3AA. 3 [redacted] the Professional Standards Officer, Boots UK, D90 EFO8, 1, Thane Road, Nottingham, Nottinghamshire, NG90 3SJ. 4. The Senior Clinical Advisor, Controlled Drugs, NHS England, c/o [redacted] Controlled Drugs Accountable Officer, NHS England & NHS Improvement, 2nd Floor, Wellington House, Waterloo, London, SE1 8UG. 5. The Chief Coroner of England & Wales, His Honour Judge Mark Lucraft [redacted] Royal Courts of Justice, Strand, London, WC2A 2LL.
1	**CORONER** I am Russell A Caller, HM Assistant Coroner, for the Coroner Area of Inner London West
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 Tuesday 10th September 2019 Russell Caller, Assistant Coroner, heard the inquest of Michael Lobban who was found dead at his home at [redacted] on Monday 23rd October 2017 **Medical Cause of Death** 1 (a) Mixed Drug Consumption **How, when and where and in what circumstances the deceased came by his death:** Michael Lobban was on a prescription of 5mg Methadone tablets and was required to pick up his prescription form Boots, Queensway London Branch on a regular basis. Michael Lobban was known to the staff at this Boots branch. On Thursday 19th October 2017 Michael Lobban picked up 68 x 5mg Methadone tablets in accordance with his prescription. The following Thursday 26th October 2017 during a Controlled Drug

	Running Balance audit check by Boots, Queensway Branch there was a disparity in the numbers of Methadone tablets. It transpires there were 51x 5mg methadone tablets missing. On the Monday prior to this audit check on Monday 23rd October 2017 (3 days before Boots discovered the disparity of 51 x 5mg of methadone tablets) Michael Lobban was found dead in his home at 31c Talbot Road London W2 5JG with, inter alia, an excessive amount of methadone in his blood (0.56 ug/ml in his blood) which amounts to a significant overdose of methadone. There were other drugs found in Michael Lobban's body in the toxicology report taken after death. **Conclusion as to the death:** Drug Related
4	**CIRCUMSTANCES OF THE DEATH** For many years Michael Lobban had been suffering from serious mental health issues and had been under the Drug and Alcohol Well-being Service (DAWS) for a number of years.. He suffered from Drug dependency and mental illness and had periods of overdosing causing self-harm and there had been threats of suicide. Michael Lobban was on a prescription of 5mg Methadone tablets and was required to pick up his prescription form Boots, Queensway London Branch on a regular basis. Michael Lobban was known to the staff at this Boots branch. On Thursday 19th October 2017 Michael Lobban picked up 68 x 5mg Methadone tablets in accordance with his prescription. On the following Thursday 26th October 2017 during a Controlled Drug Running Balance audit check by Boots, Queensway Branch there was a disparity in the numbers of Methadone tablets. It transpires there were 51x 5mg methadone tablets missing. On the Monday prior to the audit check on Monday 23rd October 2017 (3 days before Boots discovered the disparity of 51 x 5 mg of methadone tablets) Michael Lobban was found dead in his home with, inter alia, an excessive amount of methadone in his blood (0.56 ug/ml in his blood) which amounts to a significant overdose of methadone. There were other drugs found in Michael Lobban's body in the toxicology report taken after 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. The investigation carried out by The Boots Company PLC into the disparity of Methadone tablets on this occasion was slow and efforts to contact patients who were regular prescription users of methadone was not fully followed through.

	2. The audit checking of controlled drugs by The Boots Company PLC is not robust in that there is no double check in place in relation to the audit checking procedure followed by Boots. 3. There appears to be no physical check of the contents of prescription boxes when carrying out the audit of schedule 2 controlled drugs. 4. The General Pharmaceutical Council ("The Council") being the Regulator of Pharmaceutical industry in England and Wales does not have any reporting requirements for pharmacies when discovering a discrepancy in schedule 2 controlled drugs. Moreover there appear to be no investigative powers by The Council where it discovers a disparity of these controlled drugs and as a consequence there are no sanctions in circumstances where pharmacies have mislaid drugs during the course of their handling of controlled drugs.
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. It is for each addressee to respond to matters relevant to them. 1. The Council should implement industry wide policies and reporting requirements by pharmaceutical companies in relation to Drug Discrepancy for all Controlled drugs and 2.The Boots Company PLC should review its processes and procedures in dealing with occurrences of drug disparity for controlled drugs which should include: A). make robust rules to ensure contact with a patient or third party that could be affected by a disparity of controlled drugs. B) ensure the physical checking of the contents of prescription boxes for controlled drugs is robust and secure C) to implement a second check in relation to the controlled drug register for Controlled drugs.
7	**YOUR RESPONSE** You are under a duty to respond to this report within 56 days of the date of this report. I, the Assistant 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. The General Pharmaceutical Council, 25, Canada Square, London, E14 5LQ.

	2. Boots UK Ltd., Head Office, D90, 1, Thane Road, Nottingham, Nottinghamshire, NG2 3AA. 3. [redacted] the Professional Standards Officer, Boots UK, D90 EFO8, 1, Thane Road, Nottingham, Nottinghamshire, NG90 3SJ. 4. The Senior Clinical Advisor, Controlled Drugs, NHS England, c/o [redacted] Controlled Drugs Accountable Officer, NHS England & NHS Improvement, 2nd Floor, Wellington House, Waterloo, London, SE1 8UG. 5. The Chief Coroner of England & Wales, His Honour Judge Mark Lucraft [redacted] Royal Courts of Justice, Strand, London, WC2A 2LL. 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 Assistant Coroner, at the time of your response, about the release or the publication of your response by the Chief Coroner.
9	**4th October 2019** **Russell Caller** **HM Assistant Coroner** **Inner West London** **Westminster Coroner's Court** **65, Horseferry Road** **London** **SW1P 2ED**