BMA House
Tavistock Square
London WC1H 9JP

BMA

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[redacted]
HM Coroners Service, County of West Sussex
Coroner's Office, Centenary House
Durrington Lane
Worthing
BN13 2PQ

5 October 2021

Sent via email

Dear [redacted],

RE: Inquest into the death of Pauline Mcinroy Allison

The British Medical Association (BMA) has now considered the formal report under Regulation 28 to Prevent Future Deaths, following the investigation into the death of Pauline Mcinroy Allison by Mr Robert Simpson, Assistant Coroner, West Sussex Coroners Service.

We would like to emphasise our shared concern outlined within the report that more should be done to ensure patients are aware of the risks associated with emollient creams. We commend the West Sussex Fire & Rescue Service for raising awareness among both healthcare professionals and at-risk persons.

We are aware that the UK Government and the Medicines and Healthcare Products Regulatory Agency (MHRA) have worked with the Commission on Human Medicines to ensure that appropriate hazards are listed on relevant product containers, and accompanying Patient Information Leaflets provide both warnings and information regarding minimising risk. However, it is clear following Mr Simpson's investigation, more should be done so that these risks are better communicated.

As detailed in Coroner's Concerns, Mr Simpson states that patients, carers, families, care providers and GPs should be more aware of these risks – something the BMA fully agrees with. However, we don't believe that the BMA is the right organisation to achieve the required outcome.

The BMA is a trade union and professional association made up voluntarily of members, and not all doctors are members of the BMA. The BMA has never had a role for communicating patient safety alerts to the medical profession.

It is established practice that safety alerts regarding medicines and devices are sent to all doctors via the MHRA, and clinicians are already aware to make note of these alerts. We would suggest contacting the MHRA to disseminate this important safety alert to health professionals.

You may also wish to contact NHS England /Improvement who are responsible for delivery of NHS services, to see if they can communicate this message to providers. This would include pharmacist advisors in the community as well as in hospitals. We would also suggest contacting the Royal College of General Practitioners, who train and educate general practitioners throughout their careers. The medical defence

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bodies – which include the MDU, MPS and MDDUS also provide members with precautionary case studies to learn from safety incidents who could also disseminate this information.

Yours sincerely

[redacted]

[redacted]
Chair of Council

[redacted]
Chief Executive