Andrew Harris
Southwark Coroner's Court
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National Medical Director
NHS England
Wellington House
133-155 Waterloo Road
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[redacted]

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13 November 2023

Dear Coroner,

Re: Regulation 28 Report to Prevent Future Deaths – Juanita Boate Nti who died on 9 September 2020.

Thank you for your Report to Prevent Future Deaths (hereafter "Report") dated Friday 18 August 2023 concerning the death of Juanita Boate Nti on 9 September 2020. In advance of responding to the specific concerns raised in your Report, I would like to express my deep condolences to Juanita's parents and family. NHS England are keen to assure the family and the coroner that the concerns raised about Juanita's care have been listened to and reflected upon.

Your Report raises the concern that clinical practice errors were made regarding the prescription of and dispensing of oral morphine preparation to be administered to Juanita. Further, that the error would not have occurred had the lower strength of morphine been a choice on the EMIS prescription service and that the whole of the NHS should ensure local health economy wide paediatric prescribing policies.

NHS England is aware that in the last three years, there have unfortunately been three serious incidents where an incorrect oral morphine preparation was prescribed and dispensed to a baby. We are aware that issues have included a lack of awareness and clarity over a medicine being a special preparation as well as poor communication between medical professionals and with the parents of the child.

National work is underway by paediatric experts to consider what needs to be done to reduce the likelihood of a recurrence. This work incorporates several related workstreams including a specials formulary, with standardisation of strengths of paediatric oral liquids, recognition in NHS payment schemes, national guidelines, standardisation of RAG lists[1] and a national approach and input into GP Prescribing systems, including using the NHS dictionary of medicines and devices (dm+d) codes for special prescriptions. The dm+d is a dictionary of descriptions and codes which represent medicines and devices in use across the NHS. It must be used when electronic systems exchange or share information about medicines relating directly to a patient's care. I note from your Report that EMIS have already placed the special prescription on its drug data base.

[1] RAG stands for red, amber, green and the RAG List provides professional guidance for practitioners in both primary and secondary care as to where responsibility should sit for prescribing.

The national Patient Safety Team at NHS England are aware of the issues and the Royal College of Paediatrics and Child Health (RCPCH) and the Neonatal and Paediatric Pharmacy Group (NPPG) Joint Medicines Committee is currently undertaking a 'Review of the Management of the Supply of Unlicensed Liquid Medicines to Children', which includes the workstreams referenced above. NHS England awaits a statement from the Group as to next steps later in November 2023, and further actions and discussions will then then take place. We can update the Coroner once we have an update.

NHS England also understands that the Advisory Council on the Misuse of Drugs' Technical Committee is reviewing the safety of liquid morphine and will carefully consider outcomes and recommendations arising from this.

There is also national guidance from the National Institute for Health and Care Excellence (NICE) on End of life care for infants, children and young people with life-limiting conditions and guidance on the use of morphine in palliative care and young children: Morphine | Drugs | BNF | NICE

At a more regional level, a Patient Safety Learning Bulletin was circulated across South East London by South East London Clinical Commissioning Group (since replaced by South East London Integrated Care Board (ICB)) following this incident. This included key learning points relating to prescribing and dispensing of unlicensed specials. A 'Specials Team' has also been established which works across the whole health system and has incorporated work relating to the outcomes of the Serious Incident Report that reviewed the circumstances of Juanita's death. Broader work on the EMIS formulary is also progressing with the ICB's Children and Young People's Formulary Team to rationalise the number of oral liquid options from which products can be chosen.

Other London systems have also undertaken work in this area, for example North East London have undertaken local work to align their internal formulary against the national list of recommended strength specials in 2019, and updated these again in 2021: Standardised strengths of liquid medicines for children – NPPG.

The London region Controlled Drugs Accountable Officer will also be discussing this issue with all London ICB medications safety representatives and ensure regional oversight of implementation of action plans which will include communications to GPs and community pharmacists.

NHS England is also aware that of work being undertaken in other regions, including the North East, on this issue.

I would also like to provide further assurances on national NHS England work taking place around the Reports to Prevent Future Deaths. All reports received are discussed by the Regulation 28 Working Group, comprising Regional Medical Directors, and other clinical and quality colleagues from across the regions. This ensures that key learnings and insights around preventable deaths are shared across the NHS at both a national and regional level and helps us pay close attention to any emerging trends that may require further review and action.

Thank you for bringing these important patient safety issues to my attention and please do not hesitate to contact me should you need any further information.

Yours sincerely,

[redacted]

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National Medical Director