	REGULATION 28 **REPORT TO PREVENT FUTURE DEATHS**
1.	**CORONER** I am Andrew Harris, Senior Coroner, London Inner South
2.	**CORONER'S LEGAL POWERS** I make these reports under paragraph 7, Schedule 5, Coroners and Justice Act 2009 and regulations 28 and 29 of the Coroners (Investigations) Regulations 2013.
3.	**INQUEST** On 9th September 2020 Miss Juanita Boate Nti (ref 9210617), died aged 4 months, in a Paediatric Intensive Care Unit. A post mortem examination was conducted, indicating an overdose of morphine. An inquest was opened on 10th March 2021 and concluded on 27th July 2023. The medical cause of death was found to be 1a Townes-Brocks syndrome with tracheal stenosis and complex congenital heart disease, following accidental morphine overdose.
4.	**CIRCUMSTANCES OF THE DEATH** Juanita was born on 12th May 2020 and investigations determined that her complex congenital diseases were not treatable. She received palliative care from 1st July and was tenderly cared for by her parents at home with a symptom management plan devised by specialists, which included Morphine solution via her naso-gastric tube as needed. On 3rd September her condition suddenly deteriorated after a dose of morphine and she suffered a respiratory arrest on the way to hospital. She improved with urgent medication to reverse the effect of morphine intoxication, but went on to require intubation. She breathed regularly on pressure support but could not sustain spontaneous ventilation after extubation.

	Neither the Symptom Control Plan nor prescription written by the GP, just before a Bank Holiday during the pandemic, stipulated the volume of morphine solution to be administered and although the correct dose was stated, in error two concentrations were on the prescription. The pharmacist did not notice the error and failed to write the volume of the solution to be administered. She died of a combination of natural disease and accident. The failures of both the GP and pharmacist to make further enquiries to ensure the medication administration was safe related in part to the workload pressures of the pandemic. But they contributed to the death, as the child was given twenty times the intended dose. Juanita was very fragile with limited life expectancy, but would not have died when she did, without the overdose, naturally having less reserve to recover from the intoxication.
5.	**THE CORONER'S MATTER OF CONCERN** During the course of the inquest the evidence revealed matters giving rise to concern, which trigger my statutory duty to report to you. The hospital originally prescribed 120 micrograms of morphine sulphate 6 hourly and dispensed 100 micrograms per ml solution, but the strength and volume to be administered were not clearly recorded on the plan sent to the GP. The mother requested her GP by telephone to continue the prescription. The GP found only one strength of morphine on the EMIS prescription system, 10mg/5mls, confirmed to be the lowest strength available in the British National Formulary. He wrote this in the first line of the prescription and then confusingly further added "100 micrograms per ml solution, 120 micrograms 6hrly". The pharmacist did not notice that the second line contained a different concentration and dispensed the higher dose without stipulating the volume to be administered. The baby received 3mg instead of the intended 150 micrograms. Whilst both GP and pharmacist made errors in clinical practice and did not contact each other, the error would not have occurred had another strength of morphine been a choice on EMIS. EMIS have been notified and placed the special prescription on its drug data base. The local commissioning group is conducting a project to identify other special prescriptions that are not on EMIS that may pose a similar risk to safety.

6.	**THE REPORT IS BEING SENT TO:** [redacted] Chief Executive of NHS England, Skipton House, London, SE1 6LH
7.	**ACTION SHOULD BE TAKEN** Local partnership work between hospital, general practice and pharmacies has led to revised repeat prescription polices, improved standard operating procedures, a revised paediatric formulary and overall improved safety of paediatric prescribing. One of the paediatricians involved in the tragedy informed the court that a similar incident had occurred in North of England. He understood that the lessons of our fatal incident had not been applied there and that that there was a potential to prevent other deaths by ensuring that the whole of the NHS saw the benefits of local health economy wide paediatric prescribing policies. In my opinion action should be taken to prevent future deaths and I believe your organisation has the power to take such action.
8.	**YOUR RESPONSE** You are under a duty to respond to this report within 56 days of the date of this report, namely by **Friday, 13th October 2023**. I, the coroner, may extend the period. If you require any further information or assistance about the case, please contact the case officer, [redacted]

9.	**COPIES and PUBLICATION** I have sent a copy of my report to the Chief Coroner and to the following Interested Persons - [redacted] for Clapham Law Solicitors representing the family [redacted] for Clyde & Co representing [redacted] [redacted] for Gordon Solicitors representing Millennium Pharmacy [redacted] Senior Safeguarding manager of Lambeth Child Safeguarding Board. I have also sent it to: [redacted], consultant paediatrician, The Royal College of Paediatrics and Child Health, The Royal College of General Practitioners and The Royal Pharmaceutical Society, who may find it useful. The Department of Health 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.
10.	**[DATE]** **[SIGNED BY SENIOR CORONER]** **Friday, 18th August 2023**  **A N G Harris**