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Katy Thorne KC
Assistant Coroner for Berkshire
Town Hall, Blagrave St,
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20 July 2024

Subject: Response to Matters of Concern

Dear Ms. Thorne,

Re: Mrs Sewa Kaur Chaddha (deceased) Regulation 28 Preventing Future Deaths Response

Thank you for your report dated 2nd June 2024, regarding the death of Mrs. Sewa Kaur Chaddha and the concerns raised during her inquest, which concluded on 24th May 2024. On behalf of NHS Frimley Integrated Care Board (ICB), I would like to express our sincere condolences to Mrs. Chaddha's family. We deeply regret the circumstances of her passing and appreciate you bringing these important issues to our attention.

I am replying as the Chief Pharmacist for NHS Frimley, responsible for medicines optimisation and pharmacy across our system. While we recognise our duty to address the concerns raised, it is important to note that community pharmacies and other healthcare professionals operate as independent contractors under a national framework or contract, limiting our direct influence over their processes.

Your report highlights the concern about the lack of guidance for pharmacists when providing medications in dosette boxes to patients with cognitive impairments who may need additional support to take their medication safely. We are committed to addressing these issues to ensure the safety and well-being of all our residents.

Our goal is to learn from this case and take meaningful steps within our remit to prevent similar incidents in the future and share learning nationally. To thoroughly address the concerns raised, we shared the Prevention of Future Death Report [REDACTED] with a diverse group of pharmacy stakeholders across the South-East region to help the ICB respond effectively to the points you raised.

Below is a summary of the matters of concern outlined by the court and our response.

1. The medications were provided to the couple by the local pharmacy, then known as Lloyds Pharmacy, in separate dosette boxes. Mrs. Chaddha's medications were provided on a weekly basis. Mr. Chaddha's were provided monthly

The clinical need of the individual patient is determined by the patients General Practitioner which is used to determine the number of days' supply of medication. As such this can mean that patients in the same household may be supplied medication at different frequencies.

2. Both patients were elderly and had cognitive impairment.

The report mentioned that both patients had age-related cognitive impairment but did not include details of whether any assessment had taken place to establish the support required by Mr. or Mrs. Chaddha for their physical or cognitive needs by any health or social care organisation.
Community pharmacies typically have access to patients' medication records but will rarely receive any information about diagnoses or social care details.

3. The two patients' dosette boxes were identical to each other except for a small pharmacist's label with small type with the relevant patient's name.

Where requested by patients, other healthcare professionals or relatives or where an issue is recognised, pharmacy contractors will under the Equality Act 2010 make reasonable adjustments to support individuals to take their medication safely, for example, by the provision of Medicines Compliance Aids (commonly referred to as dosette boxes), tick charts or large print labels. They are advised to assess the patients' needs before making any such reasonable adjustments and not simply respond to the request of a patient, carer or other healthcare professional. It should be noted that the adjustment should be reasonable and under the Act does not include all possible solutions.

As a result of this case, the ICB will be updating local resource material to remind healthcare professionals of the importance of carrying out an assessment and will recommend that in doing so they consider other people in the home that may also have additional needs, as well as the individual patient.

4. Mrs. Chaddha used one of Mr. Chaddha's dosette boxes, rather than her own, for several days.

It remains unclear if Mr or Mrs. Chaddha had social care support that could have flagged issues earlier.

5. Evidence was given at the inquest that there was no guidance or policy in place for pharmacists to follow when issuing medication to patients with cognitive impairments, or if there was, it was not well disseminated among the pharmacist population.

In the UK, there are several sources of guidance, but there is no single national policy for healthcare professionals on managing medications for patients with cognitive impairments. Existing guidelines, such as those from the Royal Pharmaceutical Society, emphasises the need for pharmacists to provide person-centred care tailored to the individual needs of patients.

When patients are assessed, they are generally presumed to have capacity unless there is clear evidence of cognitive impairment. All healthcare professionals are expected to assess a patient's capacity, which can include evaluating their ability to retain and recall information. In this case, there was no information indicating whether such an assessment had been conducted by any healthcare or social care professionals.

We recognise that guidance documents alone are often insufficient. Lasting and effective change requires embedding these guidelines within contracts and regulations.
We will therefore inform NHS England's pharmacy team of this case and request that they consider potential changes to the Community Pharmacy Contractual Framework.

6. Evidence was given at the inquest that dosette boxes of different colours or labels with different colours were not routinely given to elderly or cognitively impaired patients living at the same address.

There are several different brands of dosette boxes available and typically a pharmacy will use one particular brand. The decision about whether such an aid is appropriate is made by the pharmacist, and we are unable to direct this choice.

Dosette boxes are not always suitable or the only solution for supporting a patient in taking their medication. Although various types of dosette boxes are available for purchase by the public, there are only a limited number used within community pharmacy due to the requirement that dosettes used must enable fulfilment of the legal labelling requirements. These are not currently available in different colours or label colours.

In response to the coroner's report, we have taken the following steps to address the concerns raised:

Action: NHS Frimley recognises the seriousness of this tragic case and acknowledges that a similar situation could occur in any system. To address this and increase awareness, we organised a cross-system meeting across the South-East region to discuss the issues raised in this report. This took place on 9 July 2024.

From these discussions, it was agreed that the circumstances of this case need to be raised on a national level. We therefore will be writing to NHS England, about this case.

This response is also being shared within the relevant system and regional groups, including our System Quality group and the Regional Quality Group.

We believe these steps are essential for ensuring the safety and well-being of our residents and we sincerely hope that raising awareness of this case and updating local guidance will help prevent similar tragedies in the future.

Thank you for bringing these matters to our attention. We hope this response demonstrates to you and Mrs. Chaddha's family that NHS Frimley has taken the concerns you raised seriously. If you have any further questions regarding our response, please let me know.

Yours sincerely,

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[redacted]

ICS Chief Pharmacist and Director of Medicines Optimisation
NHS Frimley
NHS Frimley Integrated Care Board