Regulation 28: REPORT TO PREVENT FUTURE DEATHS

	REGULATION 28 REPORT TO PREVENT DEATHS **THIS REPORT IS BEING SENT TO:** **1. Slough Pharmacy (formerly Lloyds Pharmacy) 10 Upton Lee Parade, Wexham Road, Slough** **2. Berkshire Integrated Care Board** **3. [redacted], Contractor Support Officer, Community Pharmacy England, Thames Valley** **4. Chief Executive, Local Pharmacy Commission** **5. Chief Executive, General Pharmaceutical Council** **6. Chief Executive, National Pharmaceutical Association** **7. NHS Specialist Pharmacy Service** **8. Medication And Healthcare Products Regulatory Agency**
1	**CORONER** I am KATY THORNE KC, Assistant Coroner, for the coroner area of Berkshire
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. As set out in the case of R (Dr Siddiqi and Dr Paeprer-Rohricht) v Assistant Coroner for East London, the issuing of a Regulation 28 report entails no more than the coroner bringing. some information regarding a public safety concern to the attention of the recipient. The report is not punitive in nature.
3	**INVESTIGATION and INQUEST** On 27 March 2024 I commenced an investigation into the death of Sewa Kaur Chaddha, then aged 82. The investigation concluded at the end of the inquest on 24 May 2024. The conclusion of the inquest was accident, the medical cause of death being I a Hyponatraemia I b Treatment for Hypoglycaemia I c Ingestion of Hypoglycaemic Medication II Frailty of Old Age, Decompensated Heart Failure, Cognitive Impairment
4	**CIRCUMSTANCES OF THE DEATH** (1) Mrs Chaddha had been living with her husband in Slough. They both had a number of physical health conditions requiring multiple prescribed medications. They both had cognitive impairment due to their age. (2) On 5 May 2023 Mrs Chaddha was found collapsed on the floor at their home. It was discovered that she had been taking her husbands medication instead of her own for several days, including diabetes medication. Her blood sugar levels were found to be extremely low. (3) She died on 10 May 2023 at Wexham Park Hospital of hyponatraemia caused by the necessary treatment for hypoglycaemia which was in turn caused by the accidental ingestion of hypoglycaemic medication.
5	**CORONER'S CONCERNS** During the course of the investigation my inquiries revealed matters giving rise to concern. In

	my opinion there is a risk that future deaths could occur unless action is taken. In the circumstances it is my statutory duty to report to you. The **MATTERS OF CONCERN** are as follows: (brief summary of matters of concern) 1) The medications were provided to the couple by the local pharmacy, then known as Lloyds Pharmacy, in separate dosset boxes. Mrs Chaddha's medications were provided on a weekly basis. Mr Chaddha's were provided on a monthly basis. (2) Both patients were elderly and had cognitive impairment. (3) The two patients' dosset boxes were identical to each other except for a small pharmacist's label with small type with the relevant patient's name. (4) Mrs Chaddha used one of Mr Chaddha's dosset boxes, rather than her own, for several days. (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. (6) Evidence was given at the inquest that dosset boxes of different colours or labels with different colours were not routinely given to elderly or cognitively impaired patients living at the same address.
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.
7	**YOUR RESPONSE** You are under a duty to respond to this report within 56 days of the date of this report, namely by July 26, 2024. I, the 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 am also under a duty to send a copy of your response to the Chief Coroner and all interested persons who in my opinion should receive it. I may also send a copy of your response to any person who I believe may find it useful or of interest. I have sent a copy of my report to the Chief Coroner and to the following Interested Persons [redacted] I have also sent it to [redacted]**, Kumar Medical Centre** who may find it useful or of interest. 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.

9	**Dated: 02/06/2024**  **Katy THORNE KC** **Assistant Coroner for** **Berkshire**