Regulation 28 Report to Prevent Future Deaths
Derby and Derbyshire Integrated Care Board Response

Derby and Derbyshire Integrated Care Board (DDICB) would like to extend our sympathies to the family and friends of Margaret Feeney. Please find below the ICBs response and future plans in regard to the Regulation 28 Report to Prevent Future Deaths.

If there are any areas which you feel you would like more information or to discuss in person this will be arranged.

On 11 April 2024 the coroner commenced an investigation into the death of Margaret Mary Feeney aged 78. The investigation concluded at the end of the inquest on 11 November 2024. The conclusion of the inquest was that: –

Margaret died due to taking excess prescribed medication which she had become dependent on and addicted to. She had access to excess medication because of medical prescribing decisions and arrangements leading up to a bank holiday period.

Margaret was found deceased at her home address on 1 April 2024 by her friend and cleaner. She had last been spoken to in a telephone call on 30 March 2024.

Post-mortem examination with toxicology identified the medical cause of Margaret's death as the combined toxic effects of prescribed medication which she had taken in excess. She was also identified to have pneumonia which contributed to her death. A high total morphine level suggests the potential additional taking of a morphine-based substance.

Margaret had a long history of being prescribed benzodiazepines and codeine, the latter medication for pain for diagnosed conditions. Unfortunately Margaret had become dependent on those medications and was recognised to overuse them. As a consequence, she was given seven-day prescriptions.

On 26 March Margaret's friend was concerned that Margaret was confused, and the friend and Margaret attended a GP appointment that afternoon. The GP wanted to reduce Margaret's diazepam and issued a prescription for a lower dose in a daily dose blister pack. The codeine prescription was not altered. The new diazepam prescription was with Margaret on 27 March. This was the week prior to the Easter holiday period. Margaret had received her usual Monday prescription (25 March) including diazepam and codeine. With the new diazepam prescription received on 27 March Margaret had an excess of five days of that drug. Because of the pending bank holiday Margaret received an early prescription of codeine on 28th March, which meant she had four days excess codeine.

Clearly, given her recognised dependence and overuse, there was a real and foreseeable risk that Margaret would take excess diazepam and codeine that was available to her between 27 March and her death. In addition to the toxicological evidence, when she was found deceased there were empty or near empty blister packs from the excess medication prescribed to her.

On the evidence there is no reason to consider that Margaret had deliberately taken the excess medication to cause her own death.

The following report and action plan is in response to the matters of concern revealed through the course of the inquest as below. The concerns have been reviewed with actions to prevent future deaths captured in the action plan at the end of the report. This will be reviewed as per the timescales included within the report.

Coroner concerns

I am concerned that measures are not in place at Macklin Street Surgery and Daynight pharmacy to prevent prescription of excess medication to patient's recognised to be at risk of overdose, either intentional or unintentional, who are ordinarily issued shorter period repeat prescriptions to reduce those risks. This situation arises when early prescriptions are issued due to statutory holiday periods when most pharmacies are likely to be closed. I have been informed that measures have been introduced to prevent excess prescribing by taking account of single day bank holidays, but there are no measures relating to longer bank holiday periods (e.g. Easter). With electronic patient record and data systems it seems a reasonable presumption that suitable solutions can be identified.

As I imagine that the substance of my concern is likely to apply to other GP practices and pharmacies, I have also sent this report to the Department of Health and Social Care and NHS Derby and Derbyshire Integrated Care Board.

Derby and Derbyshire ICB Response

Having reviewed your report and the outlined circumstances, DDICB recognises the serious implications of the matters raised. Addressing the concerns you have highlighted is a priority for the ICB, and are committed to taking steps to minimise the risk of similar incidents in the future.

Good Practice

Effective management of at-risk patients is critical to preventing harm and improving outcomes. In this case, several good practices were evident and should be acknowledged as part of the ongoing commitment to patient safety. These measures provide a foundation for further improvements and system-wide learning.

- The patient was appropriately identified as having a dependence on certain medications and was managed with:
    - Weekly prescriptions to minimise the risk of overdose.
    - A prompt review by a prescriber immediately after side effects (confusion) were reported.
- We have reached out to Macklin Street Surgery to support any actions they identify. Our aim is to share learning across the system to enable the scaling of improvements. Although we have not yet received the investigation summary, our offer of support has been acknowledged, and we await their response after their coroner's response is finalised. Additionally, due to the nature of the medications, the ICB has engaged with the NHS England - Midlands Controlled Drugs Area Team who have volunteered to liaise with the Community Pharmacy and to share their response when available.

Resources

A range of resources are available to support healthcare providers in managing high-risk medications and ensuring safe prescribing practices. These tools and initiatives aim to equip teams with the knowledge and frameworks needed to reduce harm and improve patient outcomes, particularly in cases of opioid stewardship and medication dependency.

- **Opioid Change Management Programme**:
  A collaborative project between Joined Up Care Derbyshire and Health Innovation East Midlands, providing tools for opioid stewardship:
  - **Quality Improvement Toolkit**: A resource for practices to implement opioid prescribing quality improvements, aligned with the National Medicines Safety Improvement Programme.
  - **Minimum Standards for Opioids Repeat Prescribing**: Guidelines for practices to develop robust repeat prescribing processes while maintaining safety and quality standards.
  - **Opioid Tapering Resource**: A concise guide to support opioid reduction efforts.
- **Clinical System Searches**: Tools available across all utilised GP systems to assist in identifying at-risk patients and supporting optimised management.

Process Updates

Ensuring that robust and flexible processes are in place is essential to managing atypical situations, such as those arising during extended bank holiday periods and when there is a change in prescribed medicines required (such as this case with identified side effects). Process improvements should prioritise patient safety while minimising disruptions to established routines. Outlined are proposed updates that are to be shared with all GP practices to enhance continuity of care and safeguard against future risks.

- **Prescription Scheduling Adjustments**:
  - Practices to change processes for prescription collection dates for patients with regular collection schedules to mid-week (e.g., Wednesday) to avoid clashes with bank holidays and minimise re-scheduling to manage prescription collections during extended bank holiday periods.
- **Consider Patient-Specific Needs**:
  - Patients with more frequent collection schedules (e.g., twice weekly) should have these routines considered during changes to prescription dates or new patient management plans.
  - Interim or one-off acute prescriptions must also account for existing schedules to avoid overlaps or gaps.
- **Acknowledge Atypical Prescribing Situations**:
  - Assess patient routines and the potential impacts of changes to prevent adverse effects, particularly on vulnerable individuals.

Utilisation of NHS EPS (electronic prescribing system) prescriptions

Clinical systems are integral to supporting safe prescribing practices and ensuring clear communication between healthcare providers. Leveraging available system functionalities can enhance the management of high-risk medications and prevent issues arising from unconventional prescribing scenarios.

One key functionality within the NHS Electronic Prescribing System (EPS) is the ability to post-date and schedule prescriptions to download only on specified dates. This feature reduces the likelihood of prescriptions being dispensed ahead of time, particularly during extended bank holiday periods, where excess medication might otherwise be provided inadvertently. These prescriptions can also be cancelled ahead of time to prevent inadvertent dispensing – useful in the event of medication changes.

We recommend promoting the use of this feature across all practices as part of a broader effort to strengthen the scheduled prescription process. Sharing this learning with system users can help make prescription management more robust and prevent potential medication-related risks.

Communication of changes / updates

- **Communication with Providers**:
  - Notify community pharmacy immediately of medication changes, especially for high-risk patients or medications with significant harm potential.
  - Establish clear dialogue during consultations to align on prescription collection schedules and current patient stocks.
- **Patient and Caregiver Engagement**:
  - Clearly communicate any changes to medication or collection schedules to the patient and/or their caregiver to ensure understanding and avoid inappropriate use.
- **Shared Care Records**:
  - Ensure shared care records are updated promptly to reflect any changes in patient management.

Clinical system updates

We acknowledge that updates to provider clinical systems could play a crucial role in addressing the issues identified. However, given the operational and developmental oversight of these systems lies with their respective clinical system providers, we believe they are best positioned to evaluate and enact the necessary changes.

As these changes are likely to involve system-wide implications and require alignment with broader national or regional policies. We will share our learning and concerns with clinical system providers with a request to consider and implement solutions that may prevent further occurrences. It may be most effective if the coroner were to also engage directly with the clinical system providers. This direct communication would allow the coroner to convey their concerns comprehensively and advocate for updates grounded in the findings of this case, ensuring a coordinated and impactful response.

Learning to Be Shared Across the System

Sharing the lessons learned from this case with stakeholders across the healthcare system is essential to fostering a culture of continuous improvement. By disseminating

these insights and recommendations, we can ensure that the entire system benefits and that similar incidents are less likely to occur in the future.

- **Identify At-Risk Patients**:
  - Proactively flag and monitor patients vulnerable to medication dependency or overdose risks.
- **Strengthen Provider Communication**:
  - Ensure timely updates between healthcare providers, particularly around patient management changes.
- **Assess Bank Holiday Arrangements**:
  - Recognise and plan for bank holiday disruptions well in advance to mitigate risks.
- **Consider EPS prescriptions (post dated)**
  - This would reduce the likelihood of prescriptions being issued ahead of time

To ensure system wide uptake and action, the ICB will ensure engagement and cascade through the following channels;

- Community Pharmacy Derbyshire Newsletter
- GP Key messages delivered to practices by the ICB Pharmacy Directorate team
- ICB Pharmacy Directorate Team Medicines safety messages shared with practices
- Prescribing Leads Forums

Please see below a timeline of proposed actions

Action number	Overview of DDICB actions	Proposed completion date
INVESTIGATION AND SUPPORT		
1a	Review investigation and lessons learnt/ actions identified by the practice. With support of the ICB primary care quality team and ICB patient safety team, identify support required	7/2/25
1b	Review investigation and lessons learnt/ actions at community pharmacy. With support of Midlands controlled drugs area team and primary care commissioning team, identify support required.	7/2/25
REVIEW AND COMMUNICATIONS		
2a	Extract shared learning from the practice and community pharmacy reports and add lessons to be shared additionally to those raised above, into an incident report, ready to be shared with system colleagues. Learning report ratified	14/2/25

	through existing governance routes	
2b	Collated learning to be shared through existing communications as identified above.	Following Derbyshire Prescribing Group (DPG) 6/3/25.
2c	At the Clinical Governance Leads meeting with general practice the Learning report will be discussed as part of the Patient safety standard agenda item.	Following Derbyshire Prescribing Group (DPG) 6/3/25.