ROYAL PHARMACEUTICAL SOCIETY

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Luisa Maria Nicholson,
HM Assistant Coroner for Devon, Plymouth & Torbay
Reference 18942608

By email via: [redacted]

15th January 2025

Dear Ms Luisa Nicholson,

RE: Regulation 28 Prevention of Future Deaths report for Mr Oliver James Billings, deceased.

We are writing to you regarding the report into the death of Mr Oliver James Billings dated 28th November 2024. We would like to express our sincere condolences to the family of Mr Billings for their loss.

The Royal Pharmaceutical Society ('RPS') is the professional leadership body for pharmacists and pharmacy in Great Britain, representing all sectors of pharmacy. Our role is to lead and support development of the pharmacy profession including the advancement of science, practice, education and knowledge in pharmacy. We transferred our regulatory role to the General Pharmaceutical Council ('GPhC') in 2010 and they now regulate pharmacy and pharmacy professionals in Great Britain.

In considering our response, we have sought input from our Expert Advisory Groups.

We acknowledge the conclusion from the inquest on 28th November 2024 that the death of Mr Billings was due to suicide and that the medical cause of his death was a result of the toxic effect of venlafaxine.

We also note the matters of concern in the report around:

[redacted]

(1) That a subsequent prescription was submitted in the knowledge that the first was cancelled or to be cancelled but that steps do not appear to have been taken or be able to be taken to ascertain the status of that prescription before the subsequent prescription was issued.
(2) That the swift dispatch of medication (whilst admittedly necessary in many circumstances) does not allow for mistakes to be noticed and/or remedied.
(3) That the onus was on Oliver to remedy the error when Pharmacy2U could not be contacted.

Regulation 28 reports provide an opportunity for learning and actions to be taken by organisations to prevent further deaths. The RPS notes from a study published in 2023 looking at the preventable deaths, that one in five coroner-reported preventable deaths involved medicines. Common medicines involved were opioids, antidepressants and hypnotics. The RPS notes that coroners expressed concerns around the major themes of patient safety and communication, including minor themes of monitoring and communication between organisations.[1,2]

High risk medicines and vulnerable patients
The recently published Royal College of General Practitioners and RPS Repeat Prescribing Toolkit[1], advises GP practices to think carefully about their arrangements for repeat prescribing of medicines. Patients should be offered regular and careful review of their medicines and the decision to prescribe high-risk medicines should always be considered on an individual basis.

The RPS recognises that general practice and community pharmacies should ensure that all high-risk medicines, and particularly opioids, antidepressants and hypnotics, are treated carefully where they are to be prescribed as a repeat medication. The GP practice, the pharmacy and the patient all need to be clear about the arrangements for ordering and monitoring of such medicines as well as frequency of and purpose of a thorough, structured medication review.[1] This may include discussions with the patient around suitability for accessing their prescribed medication via a distance-selling online community pharmacy.

The RPS would suggest to the coroner that this prevention of future death report is also shared with the Royal College of General Practitioners for wider shared learning.

Communication between healthcare providers
The RPS notes from the coroner's report that the cancellation of the EPS prescription by the GP practice to the distance-selling online community pharmacy was unsuccessful and that the GP practice was unable to get in contact with the pharmacy. We note that the report didn't include details around attempts at

1. Royal College of General Practitioners and RPS, 2024. Repeat Prescribing Toolkit [Online]. Available from: https://www.rpharms.com/resources/repeat-prescribing-toolkit [Accessed 11 January 2025]
2. France, H S., Aronson JK, Heneghan C. et al., 2023. Preventable Deaths Involving Medicines: A Systematic Case Series of Coroners' Reports 2013-22. *Drug Saf* [Online], 46. Available from: https://link.springer.com/article/10.1007/s40264-023-01274-8 [Accessed 15 January 2025]

communication from the GP practice to the distance-selling online community pharmacy.

The RPS believes that the onus should be on the prescriber and not the patient to contact the community pharmacy to discuss next steps in the event of an EPS prescription cancellation failure.

The RPS recognises that there needs to be clear routes of communication between the GP practice and the community pharmacy (including distance-selling online community pharmacies) to manage situations where EPS prescription cancellations have been unsuccessful.

NHS Digital have issued guidance on robust processes on EPS for healthcare providers.

Digital Functionality of EPS

We have sought further information on the EPS system from our Digital Expert Advisory Group on the issue of EPS prescription cancellation.

An EPS Prescription Tracker tool is available to all NHS professionals who have a smartcard (which usually includes all prescribers and dispensers of EPS prescriptions) to allow them to check the status of an EPS prescription. The sharing of information via EPS between community pharmacies needs further consideration.

We understand that there is currently future development underway for a "Clinical Tracker" for EPS which will provide Health Care Professionals access to a patient's EPS history, detailed products and dispensed status.

The RPS would suggest to the coroner that this prevention of future death report is also shared with NHS Digital for wider shared learning and comment on EPS.

Dispensing and supply of medicines from a community pharmacy

The coroner's report refers to the *'swift dispatch of medication (whilst admittedly necessary in many circumstances) does not allow for mistakes to be noticed and/or remedied'*. It is worth noting that under the NHS Community Pharmacy Contractual Framework Essential Service – Dispensing, there is a contractual obligation for community pharmacies in England to dispense medication for patients with reasonable promptness. Medicines optimisation is about ensuring that the right patient receives the right medicine at the right time. All assessments of the clinical appropriateness of a medication by a prescriber should be complete before issuing the prescription, therefore the subsequent benefits of a safe and timely supply of medicines would outweigh risks of supplying medicines efficiently.

1. Royal College of General Practitioners and RPS, 2024. Repeat Prescribing Toolkit [Online]. Available from: https://www.rpharms.com/resources/repeat-prescribing-toolkit [Accessed 11 January 2025]
2. France, H S., Aronson JK, Heneghan C. et al., 2023. Preventable Deaths Involving Medicines: A Systematic Case Series of Coroners' Reports 2013-22. *Drug Saf* [Online], 46. Available from: https://link.springer.com/article/10.1007/s40264-023-01274-8 [Accessed 15 January 2025]

Thank you for highlighting your concerns in this prevention of future death report. We will consider how we can continue to raise awareness of these important issues through our future communications and engagement with the wider pharmacy sector. We will also raise these issues with our colleagues at the professional and representative bodies for pharmacy as they also play an important role in providing advice and support to the pharmacy professions.

Please don't hesitate to contact us if you need anything further.

Yours sincerely,

[redacted]

[redacted]
Chief Executive Officer
Royal Pharmaceutical Society

1. Royal College of General Practitioners and RPS, 2024. Repeat Prescribing Toolkit [Online]. Available from: https://www.rpharms.com/resources/repeat-prescribing-toolkit [Accessed 11 January 2025]
2. France, H S., Aronson JK, Heneghan C. et al., 2023. Preventable Deaths Involving Medicines: A Systematic Case Series of Coroners' Reports 2013-22. *Drug Saf* [Online], 46. Available from: https://link.springer.com/article/10.1007/s40264-023-01274-8 [Accessed 15 January 2025]