General Pharmaceutical Council

Kevin McLoughlin
Senior Coroner of West Yorkshire

By email via: [redacted]

26 February 2025

Dear Mr McLoughlin

Re: Regulation 28 Report to Prevent Future Deaths: Mr David Joseph Crompton

Thank you for sending us your Regulation 28 report regarding the death of Mr David Crompton. We are sorry to hear about this sad death and we would like to pass on our sincere condolences to Mr Crompton's family.

By way of background, the GPhC is the independent regulator for pharmacists, pharmacy technicians and pharmacies in Great Britain. Our main job is to protect, promote and maintain the health, safety and wellbeing of members of the public by upholding standards and public trust in pharmacy. This includes maintaining a register of pharmacy professionals and premises, setting regulatory standards and investigating concerns.

We note that in the 'Matters for Concern' section of the regulation 28 report the Coroner has highlighted four concerns namely.

1.It is important that when anti-epileptic medication is prescribed by a GP that this is obtained and supplied promptly by the dispensing pharmacy. It is a matter of concern that for relatively lengthy periods on two occasions Mr Crompton was left without this important medication.

2.The evidence given by family members at the inquest was that when the pharmacy was unable to supply the prescribed Tegretol medication, it was left to them to contact other pharmacies to see if they could obtain it, rather than for the pharmacy to search for supplies.

3.The inquest was informed that following the April 2024 episode, hospital specialists commented that the absence of Tegretol for around 10 days' will likely have contributed to your seizure activity'. It is questionable whether lessons were learnt from this potentially dangerous interval.

4.Comment was made at the inquest to the effect that the pharmaceutical profession should have clear designated systems to deal with any shortages of supply encountered; for example, reference to hospital departments to ensure patients are not left without important medications. Leaflets explaining the role of those concerned in this situation were not provided.

We are aware of supply issues with some Tegretol products. While we do not have a direct role in the manufacturing of medicines or wider issues such as supply and shortages, we understand that medicines shortages can cause problems for patients and carers. We know that pharmacy professionals are also concerned and have to use their professional judgement and make decisions in challenging situations, balancing a range of factors such as individual patient needs and available supplies of medicines. Our standards require pharmacy professionals to deliver patient-centred care, which includes making the care of the patient their first concern and using their judgement to make professional decisions. This may include making decisions about providing medication in an emergency.

In November 2024 we published an article about medicines shortage, **https://www.pharmacyregulation.org/about-us/news-and-updates/regulate/struggle-around-medicines-shortages** The article states that if the pharmacy is unable to supply a particular medicine stated on prescription then they should talk to the patient to discuss their options. The article outlines examples of steps the pharmacy should take.

On receipt of the regulation 28 report, the circumstances surrounding the death and the Coroner's concerns have been considered, together with how the GPhC needs to act to protect the safety of patients, uphold standards and maintain public trust in pharmacy.

Inspection

The particular pharmacy has been inspected by our Inspection Team, who looked for evidence that the pharmacy was meeting our Standards for Registered Pharmacies. The purpose of these standards is to create and maintain the right environment in pharmacies to protect and improve people's health and wellbeing. The inspection included looking for evidence about the systems in place to manage medicines which were out of stock at the pharmacy and where there were supply issues at the wholesalers. This was to ensure practices in the pharmacy relating to stock management were appropriate.

The Inspection report will be published in due course. Evidence collected during the inspection shows that the pharmacy has robust processes in place to manage out-of-stock medicines, including for Tegretol. The pharmacy uses electronic ordering, with a twice daily check by team members. Patients can receive a text message to inform them when their medicines are available. The pharmacy obtained its medication from recognised wholesalers and all team members across the company accessed a communication platform for queries such as checking stock availability.

Action Taken by our Enforcement (Fitness to Practise) Team

The GPhC Fitness to Practise team investigates concerns about individual pharmacy professionals where there may be a risk to patient safety and/or where public confidence in pharmacy could be affected. The initial assessment of this case is complete, and an investigation is open. The case has been allocated to a Case Officer who will consider the findings of the GPhC inspection and whether any further evidence is required. Once the investigation is complete, we will assess the evidence in line with our Threshold Criteria to determine whether further action against the individual pharmacist is required.

We have opened an investigation into the concerns raised in the regulation 28 report. The Case Officer has been in contact with the Coroner's Office to request documentation relating to this matter as part of our investigation. Once received the documentation will be assessed by the Case Officer together with other evidence collected as part of the investigation.

We hope this information is helpful. If you should require any further information, please do not hesitate to contact me.

Yours sincerely

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Chief Executive and Registrar
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