[redacted]
Midway Pharmacy
46 Chapeltown
Pudsey
LS28 8BL

Mr Kevin McLoughlin
HM Senior Coroner for West Yorkshire
Burgage Square
Merchant Gate
Wakefield
WF1 2TS

26 February 2025

Dear Sir,

RE: Regulation 28 Report to Prevent Future Deaths- David Joseph Crompton (deceased)

Thank you for your Report to Prevent Future Deaths dated 31st December 2024, concerning the death of David Joseph Crompton on 13th December 2024. In advance of responding to your concerns, I would like to express our deep condolences to Mr Crompton's family and loved ones. Midway Pharmacy is keen to assure the coroner and family that the concerns raised have been taken seriously and reflected upon.

I respond to each of the matters of concern raised in your Report below:

(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.

We take patient safety very seriously at Midway Pharmacy and endeavour to dispense medication to all our patients in a safe and timely manner. Standard Operating Procedures (SOP) are reviewed robustly to ensure owings are identified promptly. Colleagues are also engaged and actively supported to ensure strict adherence to these processes. As part of managing owings due to supplier shortages, colleagues regularly attempt to source medication from a nearby Midway Pharmacy or by ordering from different wholesalers. Where a medication is prescribed by brand, and there is a clinical risk of switching brands, the patient is advised to try another pharmacy before obtaining an alternative brand from the GP. It is noted that the patient was advised to try another pharmacy due to the clinical risks of switching brands in epilepsy patients and the prescription was returned and made available for the patient to have it dispensed in another pharmacy.

Whilst all processes were followed as above, we identified a need for clearer wording on our SOP to ensure comprehensive notes are made on patient records detailing

outcomes of patient interactions to ensure completeness of patient's medical records. The wording on our SOP has also been changed to make this clearer to colleagues.

(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.

The process of managing owings is staged to ensure we obtain patients' medications in a prompt and timely manner. On this occasion, only a single supplier (AAH Pharmaceuticals) had the medication in stock, and other Midway pharmacies could not obtain supplies. There was a clinical risk of changing the brand of medication supplied due to the condition being treated, and Mr Crompton was referred to other pharmacies that may have had the medication in stock.

From our findings, national medication shortages played a significant role in our inability to obtain Mr Crompton's medication. This is not unique to Tegretol but regularly impacts the profession, as detailed in the Community Pharmacy England Report on Medication Shortages, which can be found here:

https://cpe.org.uk/wp-content/uploads/2024/05/Pressures-Survey-2024-Medicines-Supply-Report-Final.pdf

This report highlights the worsening medicine supply problems affecting pharmacy teams and patients daily. With significant medicine supply challenges, it is imperative that we get a national resolution to ensure the continued supply of high-risk medications that our patients so dearly need.

(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.

We have clear processes and procedures in place to ensure incidents are logged for reflection and improvement. Our medication incident reporting system is also tailored to support quick and clear incident logging to ensure the process is not a deterrent to logging in a busy pharmacy environment. Once logged, there are processes in place to ensure incidents are investigated within 7 days, and learnings are shared across the organisation and as part of Monthly Pharmacy Governance sessions. Following thorough checks and investigations, we have been unable to confirm the pharmacy was notified of the incident mentioned in April 2024. However, the case as a whole has provoked a great deal of reflection and emphasises the significant impact of national medicine supply shortages related to Tegretol.

(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 medication and that the leaflet explaining the role of those concerned in this situation were not provided.

We would like to reassure the coroner and Mr Cross's family of Midway Pharmacy's commitment to clear and robust processes in the safe management of pharmacy services. From 3rd March 2025, where a verbal communication to a patient and more information to support the details provided, the patient will be supplied with the Community Pharmacy England 'Medicines Supply' leaflet. A copy of this can be found here:

https://cpe.org.uk/wp-content/uploads/2024/03/Medicines-supply-leaflet-March-2024-Colour.pdf

In addition to referring patients to a pharmacy, patients are also referred to their GP for a clinical review. To support this, the SOP has also been highlighted the importance of referring patients to the local hospital as the next step, if their GP is unable to support further.

We consider that an urgent review of the national medicines supply chain is critical in addressing the current medication shortages experienced by the profession. The circumstances of this case highlight that the reliable supply of medication is crucial, especially with high-risk and life-saving medications.

Thank you for bringing these matters to our attention. We hope this response demonstrates to you and to Mr Cross's family that Midway Pharmacy has taken the concerns you have raised seriously. If you have any further queries regarding our response, please let me know.

Yours Sincerely,

[redacted]

Superintendent Pharmacist
Midway Pharmacy