Cumbria, Northumberland,
Tyne and Wear
NHS Foundation Trust

Safer Care
St Nicholas Hospital
Jubilee Road
Gosforth
Tyne and Wear
NE3 3XT

Mr David Place
HM Senior Coroner for the City of Sunderland
City Hall
Plater Way
Sunderland
SR1 3AA

10th February 2026

Dear Mr Place

Inquest into the death of Valerie Jane Gibson
Response to Regulation 28 Report; Prevent Future Deaths Response

This response has been prepared by Cumbria, Northumberland, Tyne and Wear NHS Foundation Trust ("The Trust") and addresses the concerns as set out by HM Senior Coroner in his Regulation 28 Report dated 17 December 2025 following the investigation into the death of Valerie Gibson.

Digital medicines technologies such as electronic prescribing (EPMA) and automated dispensing (Omnicell) are supportive tools which evidence shows reduce medication errors and costs while improving productivity. However, they remain reliant upon clinicians' due diligence and professionalism when interacting with these tools, underpinned by appropriate education, training and robust governance arrangements.

Based on the evidence heard at inquest and the concerns of HM Coroner; the Trust has stood up an executive led Incident Management Review Group comprising of senior operational staff, pharmacy leads, service leads, training leads and patient safety specialists. It has focused on the human / system interface, professional culture, and training and competency assessment in medicines administration to address the concerns.

The Trust will respond to each of the Coroner's concerns in turn.

1. ***Evidence highlighted significant staff uncertainty and confusion as to the correct process for dispensing and administering of medication resulting in complete lack of clarity as to what medication had been dispensed and what had been administered to patients which could easily lead to patients being over or under medicated.***

   Trust Response

   The Trust has already taken several actions in relation to this concern, with additional actions underway. These actions are in some cases applicable across several of the Coroner's concerns.

- An alert on the Trusts Access Request Management System (ARMS) has been established to alert ward-based pharmacy teams whenever a new member of Trust nursing staff commences employment so that face to face Omnicell training can be delivered during their induction period.

- Ward based pharmacy teams have received updated face to face Omnicell training, this updated training has also been offered to nursing teams across bed based services.

- Omnicell guides and training checklists have been updated and are available to all staff on the Trust intranet and have been circulated via the Trust bulletin.

- Nursing staff medicines competencies have been reviewed and updated to include use of EPMA and Omnicell.

- The Trust Medicines Optimisation Policy and medicines management e-learning package have also received updates related to Omnicell task competencies and use of EPMA, policy updates have been circulated to staff via the Trust policy bulletin.

- The Trust has adopted the '6 Rights of Medicines Administration' (6R's), a NICE-recommended safety framework designed to reduce the risk of medication errors during the administration process in health and care settings. The 6R's are, Right Patient, Right Medicine, Right Dose, Right Route, Right Time, Right Documentation. The Framework is to be rolled out across CNTW, posters have been prepared for circulation and are awaiting approval of the Medicines Optimisation Committee (MOC) on 11/2/26. With Trust wide communications via the Bulletin and pharmacy Internet page to follow thereafter.

- In addition to the above, a Task and Finish group has been established to develop further actions and initiatives related to safer practice in medicines administration. The group met initially on 22/1/2026 and are scoping:

    - Mandatory Omnicell training and assessment for nurses with centralised record keeping;
    - Further review of medicines competency assessment to make it more practice based, providing enhanced support and guidance for the assessment and competency of nursing staff. This will also cover how to support staff who do not meet the required competency level.
    - Current barriers for safe medicine administration practice and possible solutions e.g. Ward Medicine Assistants, medicine management / digital nurse leads.

2. *There was not a thorough check of Valerie's possessions which arrived after she had been admitted. Additional tablets were found in a coat pocket and*

that coat was one of the possessions that arrived the day after her admission and was given to her without being checked.

Trust Response
The Trust has a policy CNTW(C)11, complimented by local operational procedures held at ward level, these are being reviewed and updated with the learning from this case. In relation to this concern, the current process around the checking of property is to be reinforced to ensure that all clothing pockets are checked as part of a property search. This will be made explicit in the search policy and associated training.

3. *Evidence highlighted a lack of understanding about supervision requirements for preceptee nurses resulting in medication being administered without supervision and being recorded on a patient's electronic medication record (ePMA) as being administered by a different registered nurse.*

Trust Response

In line with national guidance the Trust policy remains that the nurse who dispenses the medication must administer it to the patient and record the administration on ePMA. If a medicines round is being completed with a preceptee or student, they should be supervised / accompanied throughout the entire process. In response to the learning highlighted in this case, a scenario of a medicines round being conducted as part of a student or preceptees training will be included in scenario based training as part of the review of the medicine's competency assessment for qualified nursing staff.

4. *There was no consistency in the evidence from the nursing staff as to the correct use of the Omnicell medication cabinet and the electronic medication record (ePMA). Between 27th and 29th October 2023 Valerie's Omnicell record showed that liquid oral morphine solution had been selected for her. However, she was not prescribed this medication. Her electronic medication record (ePMA) showed that morphine modified-released capsules were administered to her, which was her prescribed medication.*

Trust Response

In addition to actions outlined under concern 1, the following has occurred:

A) The pharmacy team has led a Trustwide switch from morphine sulphate oral solution 10mg/5ml (Oramorph) to morphine sulphate oro-dispersible tablets (Actimorph), as the preferred 1st line product. This will reduce the issues highlighted in this case regarding the use of liquid Controlled Drugs (CD's).
B) Further guidance on the reporting of CD discrepancies has been added to the Trust Medicines optimisation policy. The Nurse Medicines competency assessment has had additional content added regarding medicines formulations (immediate release vs modified release).

From a governance and assurance perspective the following is underway:

A) A CD stock adjustment report to highlight unusual Omnicell stock balance adjustments is in development, and an escalation process has been agreed with bed-based services.
B) Operational Nurse Directors are responsible for ensuring ward based staff are aware of the need to report any CD discrepancies.
C) Aligned with this, the Controlled Drugs Accountable Officer delivered a controlled drugs briefing to operational nurse managers in January 2026.

The Trust are also working with its electronic care records system supplier to explore the possibility of an automated reporting of stock balance adjustment report from the Omnicell system.

5. *Each nurse had a different understanding as to what the correct procedure was to dispose of liquid medication incorrectly dispensed.*

Trust Response

The Trust have in place a medicines optimisation policy and an e-learning module that covers the procedure for disposal of liquid medications. However, considering the learning highlighted by this case, we have taken the decision to review and amend the nurse medicines competency assessment, which will include liquid medicines disposal. All qualified nursing staff complete the competency assessment every 3 years. A Task and Finish group has commenced this piece of work and is being supported by pharmacy input, as described in 1 above.

6. *The Omnicell and electronic prescribing and medicines administration system (ePMA) are two distinct digital systems that operate alongside each other, with patient demographic details shared between them. Omnicell reduces the risk of drug selection errors by guiding the nurse to the correct location within the cabinet for the prescribed medicine. However, the evidence highlighted that this approach still requires the nurse to select the correct medicine from the stock held within it and does not reduce the risk of selection errors to zero.*

Trust Response

Potential integration of the two systems (a ‘closed loop system’) has been considered in conjunction with NHS England and Omnicell. At the present time integration of Omnicell and EPMA is not a viable option. There is limited published evidence from the acute sector of successful integration and no examples of integration within a Mental Health Trust. The process of integration would involve significant financial investment as well as the introduction of patient allocated barcodes / wristbands, which may bring unintended patient safety risks and would require careful consideration and consultation with stakeholders.

The Trust will continue to work with the system suppliers to improve connectivity and innovation to enhance patient safety and workflow.

7. *The evidence confirmed that on occasion the patient's electronic medication record (ePMA) showed that medication had been administered to the patient before it had been dispensed from the Omnicell cabinet, with nurses admitting this was likely done to reduce workload during a busy medication round.*

Trust Response

In relation to this finding the Trust has added a segment to its medication administration e-learning package around 'the Rights of Medication Administration'. A poster for display in clinics / dispensing areas has also been produced to raise awareness. In addition, the review of the medicine's competency assessment will include a section on the correct sequencing involved in medicines administration. The Trust Pharmacy service is also in the process of developing educational / instructional videos to support the use of Omnicell.

8. *The evidence appeared to suggest there was an alternative way to access controlled drugs within the Omnicell cabinet without the use of a 2nd fingerprint signature, by using a stock code normally used by pharmacy staff when restocking the cabinet.*

Trust Response

Further investigation of this concern has occurred since the inquest, and while an incorrect restock code (as opposed to a medicines issue code) was used to open the patient's own medicines drawer, this did not allow access to the controlled drug compartments (bins) within the drawer. The controlled drug compartments (bins)require two fingerprints to open. Therefore, controlled drugs remained accessible only through the use of a 'witness' fingerprint from a 2nd nurse.

We hope that the information provided offers the necessary assurances that the Trust has acted in light of the concerns raised and continues to look to improve and strengthen its systems, processes and staff competency.

We would also like to extend again our sincere condolences to the family of Valerie.

Yours sincerely

[redacted]

[redacted]
Executive Director of Nursing and Therapies