David Place
Senior Coroner for the City of Sunderland

	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO:** **Chief Executive of Cumbria, Northumberland, Tyne and Wear NHS Foundation Trust**
1	**CORONER** I am David Place, His Majesty's Senior Coroner for the City of Sunderland
2	**CORONER'S LEGAL POWERS** I make this report under paragraph 7, Schedule 5, of the Coroners and Justice Act 2009 and regulations 28 and 29 of the Coroners (Investigations) Regulations 2013. http://www.legislation.gov.uk/ukpga/2009/25/schedule/5/paragraph/7 http://www.legislation.gov.uk/uksi/2013/1629/part/7/made
3	**INVESTIGATION and INQUEST** On 29th October 2023 I commenced an Investigation into the death of Ms Valerie Jane Gibson, who died in Monkwearmouth Hospital, Sunderland on 29th October 2023 aged 64 years. The Investigation concluded at the end of the Inquest on 5th December 2025. The medical cause of death was confirmed as: - Ia The cardiac effects of olanzapine and left ventricular diastolic dysfunction II Liver fibrosis and the effects of morphine, diazepam and temazepam The Jury recorded a narrative conclusion 'Natural causes contributed by the use of olanzapine to treat psychosis.'
4	**CIRCUMSTANCES OF THE DEATH** Valerie died on 29th October 2023 at Monkwearmouth Hospital. She had been admitted to the hospital on 21st October 2023 under s2 Mental Health Act 1983. She was suffering from delusional thoughts, hallucinations and persistent thoughts in keeping with psychosis and possible depressive illness. She was assessed to be at risk of self-harm and a risk to others. The working diagnosis was paranoid schizophrenia. Although her property was checked upon admission, she received more possessions the day after her admission, and these were not checked and were given to her. These included a coat which contained one type of her prescribed medication. She had not been compliant with taking prescribed medication to treat psychosis prior to her admission so this was restarted at a low dose of which increased on 27th October 2023. Between dates of 27th October 2023 - 29th October 2023 there was uncertainty whether she had received her prescribed or non-prescribed medication. She was found unresponsive at 08:26am on 29th October 2023 having been observed to be snoring at 07:45am.

5 **CORONER'S CONCERNS**

During the course of the Inquest the evidence revealed matters giving rise to concern. In my opinion there is a risk that future deaths will occur unless action is taken. In the circumstances it is my statutory duty to report to you.

The **MATTERS OF CONCERN** are: –

Valerie was an extremely vulnerable woman who had suffered with mental health concerns for a number of years. She was admitted to Monkwearmouth Hospital on 21st October 2023 under s2 Mental Health Act 1983.

The matters of concern are not found to be causative of Valerie's death but are such that there is a risk that future deaths may occur unless action is taken.

I was concerned that the 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.

It became clear in evidence that there was not a thorough check of Valerie's possessions which arrived after she had been admitted. All possessions, no matter when they arrived, should have been checked. 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. On balance of probabilities, toxicology suggested that Valerie had not consumed additional tablets over and above her prescribed dose, but there was clearly the opportunity for her to do so with staff admitting they would not have known if she had.

The evidence highlighted a lack of understanding with regard to 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.

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). This resulted in different approaches being taken leading to differences between medication recorded as being dispensed from the Omnicell cabinet and that being recorded as administered to the patient on the electronic medication record (ePMA). Between 27th and 29th October 2023 Valerie's Omnicell record showed that liquid medication had been dispensed for her. She was not prescribed this medication. Her electronic medication record (ePMA) showed that tablet medication was administered to her which was her prescribed medication.

Each nurse had a different understanding as to what the correct procedure was to dispose of liquid medication incorrectly dispensed. One thought it went straight into the blue disposal bin but the other did not think that was the case. The group medical director also had a slightly different view that a liquid could be disposed of in the blue disposal bin if it was in a sealed container. This added to the confusion over which medication had been administered to Valerie.

It was apparent that the Omnicell and electronic medication record (ePMA) are two distinct and separate systems that are supposed to be used alongside each other but the evidence highlighted the potential flaws in that approach due to the reliance on the person using the system adopting the correct approach. I was shocked that the Omnicell did not refer to a patient's prescribed medication and relies on the nurse dispensing to have correctly identified from the patient's electronic record (ePMA) the correct prescription and then inputting the correct medication and dose to the Omnicell. Differing amounts were inputted and on 28th October 2023 and stock levels of the non-prescribed liquid medication showed a significantly large reduction which was over 3 times a normal dose with

	no evidence a spillage had occurred and no incident report completed. In addition, small doses were inputted to enable the medication to be returned to the cabinet if the door had shut before the nurse had replaced the bottle. This led to complete confusion over stock levels, what had been dispensed and whether it had been disposed of or administered to the patient. The evidence confirmed that on occasions the patient's electronic medication record (ePMA) showed that medication had been administered to the patient before it had even been dispensed from the Omnicell cabinet with nurses admitting this was likely done to reduce workload during a busy medication round. This resulted in Valerie being recorded as receiving all of her medication on the morning of 29th October 2023 which was not the case as she was sadly found unresponsive before any medication was given to her and subsequently passed away. The evidence suggested there were alternative ways 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 when restocking the cabinet adding to the confusion over what was dispensed and what was administered. I shall be glad to be told of any learning arising from this death and timescales and results of your review.
6	**ACTION SHOULD BE TAKEN** In my opinion action should be taken to prevent future deaths and I believe you have the power to take such action.
7	**YOUR RESPONSE** You are under a duty to respond to this report within 56 days of the date of this report, namely by 11th February 2026. I, the Coroner, may extend the period. Your response must contain details of action taken or proposed to be taken, setting out the timetable for action. Otherwise, you must explain why no action is proposed.
8	**COPIES and PUBLICATION** I have sent a copy of my report to the Chief Coroner and to the following Interested Persons: - • Family and their Solicitors • Nurse L and her Solicitors • Care Quality Commission I am also under a duty to send the Chief Coroner and all interested persons, who in my opinion should receive it, a copy of your response. The Chief Coroner may publish either or both in a complete or redacted or summary form. She may send a copy of this report to any person who she believes may find it useful or of interest. You may make representations to me, the coroner, at the time of your response, about the release or the publication of your response by the Chief Coroner.
9	Dated this 17th day of December 2025 Signature: [redacted] HM Senior Coroner for the City of Sunderland