SUNDON MEDICAL CENTRE

142-144 Sundon Park Road, Sundon Park, Luton LU3 3AH
[redacted]

08 May 2026

Natalie Shirran
Principal Coroner's Officer
Bedfordshire & Luton Coroner's Service

[redacted]

Prevention of Future Death Report following Inquest touching on the death of Mr Paul Nash.

Dear Ms Shirran

I am writing to reply to the documents sent to us recently relating to the above-named deceased patient and subsequent inquest:

1. Regulation 28 Report to Prevent Future Deaths dated 19 March 2026

In section 5 of the Regulation 28 you have stated the following: Coroners Concerns.

During the course of the investigation my inquiries revealed matters giving rise to concern.

In my opinion there is a risk that future deaths could occur unless action is taken. In the circumstances it is my statutory duty to report to you.

The **MATTERS OF CONCERN** are as follows:

(brief summary of matters of concern)

For GP Surgery only:

1. During the phone call with the Surgery on 21 October 2025, HEADWAY made it clear to the Surgery that the Deceased had run out of his Carbamazepine (seizure medication) completely and, although he had taken that morning's dose, if he did not receive more medication that day he would not have his evening dose or any other doses. Although HEADWAY was reassured that the GP would be notified that the Deceased had run out of his seizure medication, this fact did not appear to have been conveyed to the GP and the prescription was not prioritised to ensure he received it the same day.

We were saddened to learn of the death of Mr Nash on the 23 October 2025. We have taken this matter extremely seriously and had commenced actions immediately after the Inquest and before the Regulation 28 Report was issued.
These are the actions taken and details of plans to take forward.

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Action to address the concern regarding the medication request made by Headway and the fact the reassurance that the GP would be notified and the prescription prioritised did not happen.

Following Mr Nash's death the practice raised a Significant Event Concern and have revisited this on a number of occasions.

Critical Medications list. We have created a Critical Medication List where missing of doses may lead to significant harm.

Prescribing instructions to clearly state indication and total dose. For these medications the repeat template must state what the medication is for (indication) after the dose so that both the reception team and any clinician unfamiliar with a patient will know why the medication is being taken. This has been completed for all epilepsy medications.

Additional safeguards for split-strength medication regimens. Where patients are prescribed more than one strength of a given critical medication the practice will ensure that prescribing instructions clearly state the **total dose** on each repeat template of that medication and make it explicit that the doses are **to be taken together**. This is intended to reduce the risk of only one item being issued or requested in error. This also makes clear to reception staff who are not medically trained what the medication is used for and also to clinicians who may not be familiar with the patient for whom they are signing medication. The SEA identified this as an important learning point following this incident. This has been completed for all epilepsy medications.

Example:

Carbamazepine 200mg tablets- Take one tablet twice daily for epilepsy in addition to 100mg tablets to make a total dose of 300mg twice daily.

Carbamazepine 100mg tablets- Take one tablet twice daily for epilepsy in addition to the 200mg tablet to make a total dose of 300mg twice daily.

Critical medication escalation process- the practice is introducing a formal process for identifying and escalating requests relating to critical medications including anti-epileptic medication. Where a patient reports that they have run out, or are about to run out of such medication, this will be treated as a priority medication safety issue and escalated promptly for same day review by an appropriate clinical or prescriber. Where such a task is sent to the Duty Clinician it will be flagged as urgent and an instant message will also

be sent to that clinician advising of the urgent task requiring attention. Training has been undertaken in this and we are currently monitoring and auditing to ensure that this is happening.

Written medication requests only. The practice has reinforced that medication requests should be submitted in writing, including through approved electronic routes or the triage system, rather than being taken over the telephone. This is intended to improve accuracy, create a clear audit trail and reduce the risk of misunderstanding or omission when medications and dosages are requested. Patients or their carers may request 'seizure medication' or 'heart medication' which could lead to errors as clerical staff are not medically trained.

Repeat dispensing / batch prescribing for suitable patients. For patients prescribed long term critical medication, the practice will consider whether repeat dispensing or batch prescribing with future dated repeat prescriptions for up to six months is appropriate, particularly where patients may have memory difficulties, cognitive impairment, or other vulnerabilities that place them at risk of running out of medication. This will be assessed on a case by case basis to ensure suitability and safety. Where patients have experienced difficulty obtaining medication on time the practice will consider prescribing a one-off extra medication prescription to provide patients with a month of their time critical medication in hand.

Enhanced support for vulnerable patients. Where a patient is known to have memory difficulties, cognitive impairment, brain injury and / or reliance on relatives / carers for medication support, the practice will consider whether additional medication safety measures are needed. This may include review of dispensing arrangements, earlier intervention where requests are irregular and clear recording of any relevant support arrangements.

Informing Epilepsy Patients of the Charlie Card - this is a self advocacy tool designed to assist individuals with epilepsy who find themselves without their regular anti-seizure medications. It highlights the legal framework under the Human Medicines Regulations 2012, allowing patients to request an emergency supply of anti-seizure medications from any pharmacy without a prescription, provided certain conditions are met. The card serves as a reminder to pharmacists of their legal duties and aims to ensure that patients can access life- saving medications quickly and efficiently. The Charlie Card is available free through the charity shop of SUDEP Action and individuals can also download a copy.

Staff training on critical medications and escalation. Reception and administrative staff have received and will continue to receive further training on:

-recognising critical medications,

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-identifying and issuing split strength medications on repeat

-escalating concerns promptly to the duty doctor or prescribing clinician

-checking communication carefully to ensure all requested items are clearly identified.

The practice recently spent a PLT (Protected Learning Time) session on Reception Safety training (25/03/26) which included prescription requests safety training as highlighted by the significant event. This included working through procedures and various scenarios

Clear patient information regarding repeat turnaround times The practice will continue to ensure that patients are clearly informed that repeat prescriptions require a two working days for surgery processing and that pharmacies require additional time for dispensing. This information will be displayed on the website and in reception to encourage timely ordering and reduce the risk of medication running out.

Pharmacy communication for urgent critical medication. Where a patient has run out of critical medication and an urgent prescription is issued, the practice will ensure that the urgent nature of the request is clearly highlighted with the pharmacy to support prompt dispensing.

Local Pharmacies have access to our bypass back office telephone number.

We also have a dedicated pharmacy direct email in box (as required by the new GP contract for 2026)

Audit and Review. The practice will undertake a review of these changes after implementation to ensure they are embedded and effective. This will include monitoring compliance with the new process for urgent critical medicines, checking the use of clear dosage wording for split-strength prescriptions and reviewing whether staff are following the written request and escalation process consistently.

Yours sincerely

[redacted]
On behalf of Sundon Medical Centre.