

Please reply to:

Acting Chief Executive

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Bridget Dolan  
Assistant Coroner  
H M Coroner for West Sussex  
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West Sussex  
PO19 1DD

By recorded delivery


4 June 2014

Dear Ms Dolan

Thank you for your letter dated 25 March 2014, and the enclosed Regulation 28 Report to Prevent Future Deaths, following the Inquest into the death of Kerry Jacobs.

The Trust has taken the Regulation 28 Report very seriously and is keen to implement the changes that will prevent a similar event from happening again. I note from your Report the two areas of concern arising from the Inquest, and submit the Trust's formal response to these issues as follows:

1. There is no policy or procedure within the Trust which requires a doctor who prescribes medication outside usual practice and / or BNF guidelines to note within the patient's clinical record that they have made the deliberate decision to do so and to record their grounds for so deciding.

Response: It is correct that there is no formal Trust policy in place, however,  Chief Medical Officer, has issued a directive to the Chiefs of Service in the Divisions (see attached email dated 4 June 2014) that all staff should record and specify the rationale for the decision to prescribe a medication dosage that is outside guidance within BNF, or usual practice. In addition, when a query is raised by a pharmacist regarding a patient's prescription, an entry must be made within the patient's medical records, noting the discussion and outcome. This directive will be disseminated to the clinical staff within each Division, at Multi Disciplinary Team (MDT) meetings each week, and departmental meetings; and will be added to the Trust's Audit Programme for 2014/2015.

It is the Trust's expectation, and it is set down in the health professionals' Codes of Conduct, that when prescribing medication to a patient the decision is based upon the patient's clinical diagnosis, symptoms, with reference to the BNF guidance, and based upon the clinicians' expertise, and knowledge of the patient.

2. There is no policy or procedure within the Trust that requires a discussion between the prescribing doctor and the dispensing pharmacist, if and when there is a query regarding a prescription of a drug

Response: It is correct there is no formal Trust policy in place, however, [REDACTED] Chief Pharmacist, has re-iterated the medication screening procedure to the Trust's Pharmacy Technicians and Pharmacists. I attach a copy of his email communication dated 7 May 2014 in which he specifically has instructed the Pharmacy Department that "the prescribing clinician and the screening and dispensing pharmacist must have an inter-professional direct discussion about the prescription (not via secretaries), and if the prescribing clinician is not available, then the pharmacy technician or pharmacist must speak to another prescriber/ clinician who is able to make a decision."

[REDACTED] has informed me that he has shared the above together with contact information for the Trust's Lead Pharmacists with the CCG Lead Pharmacists and GP practices, in an email communication and the "GP newsletter" so they may inform community pharmacists of the Trust's procedure. Please see the attached email correspondences dated 27 and 29 May 2014.

The Trust is conscious that the prescription of steroids did not cause or contribute to the death in this case, but I hope you are satisfied with the actions that have been taken and that the risk of future deaths occurring in similar circumstances is reduced.

Yours sincerely



**Paul Simpson**  
**Acting Chief Executive**