REGULATION 28: REPORT TO PREVENT FUTURE DEATHS (1)

*NOTE: This form is to be used **after** an inquest.*

	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO:** **1.** Mr Paul Bennett, Chief Executive Officer of the Royal Pharmaceutical Society, 66 East Smithfield, London, E1W 1AW
1	**CORONER** I am Rachael Clare Griffin, Senior Coroner, for the Coroner Area of Dorset
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.
3	**INVESTIGATION and INQUEST** On the 11th April 2019, an investigation was commenced into the death of Brenda Anne Drew, born on the 16th April 1947. The investigation concluded at the end of the Inquest on the 27th November 2019. The Medical Cause of Death was: 1a Fatal intoxication with Morphine The conclusion of the Inquest was accident.
4	**CIRCUMSTANCES OF THE DEATH** On the 10th November 2018 the deceased, who was partially sighted, fell at her home address and sustained a right fracture of the distal end of the radius. Following attendance at Poole Hospital, Poole, she was prescribed Oramorph upon discharge for pain relief. This continued to be prescribed by her GP without review until the 29th March when she was told to stop taking it. On the 6th April 2019 she was found in a collapsed and unresponsive condition at her home address. Toxicology testing following her death revealed a fatal level of morphine in her blood.
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 as follows:

1. During the inquest evidence was heard that:

   i. Mrs Drew was prescribed 100ml of Oramorph by the hospital for pain relief following her fracture. At that time she was also prescribed other medications on a routine basis by her GP for unrelated conditions. These other medications were on repeat prescription. These prescriptions were requested on her behalf by Lloyds Pharmacy in Ashley Cross, Poole. The prescription requests were sent to her GP at Wessex Road Surgery, Poole who authorised the requests and then Lloyds pharmacy would prepare the medications for Mrs Drew.

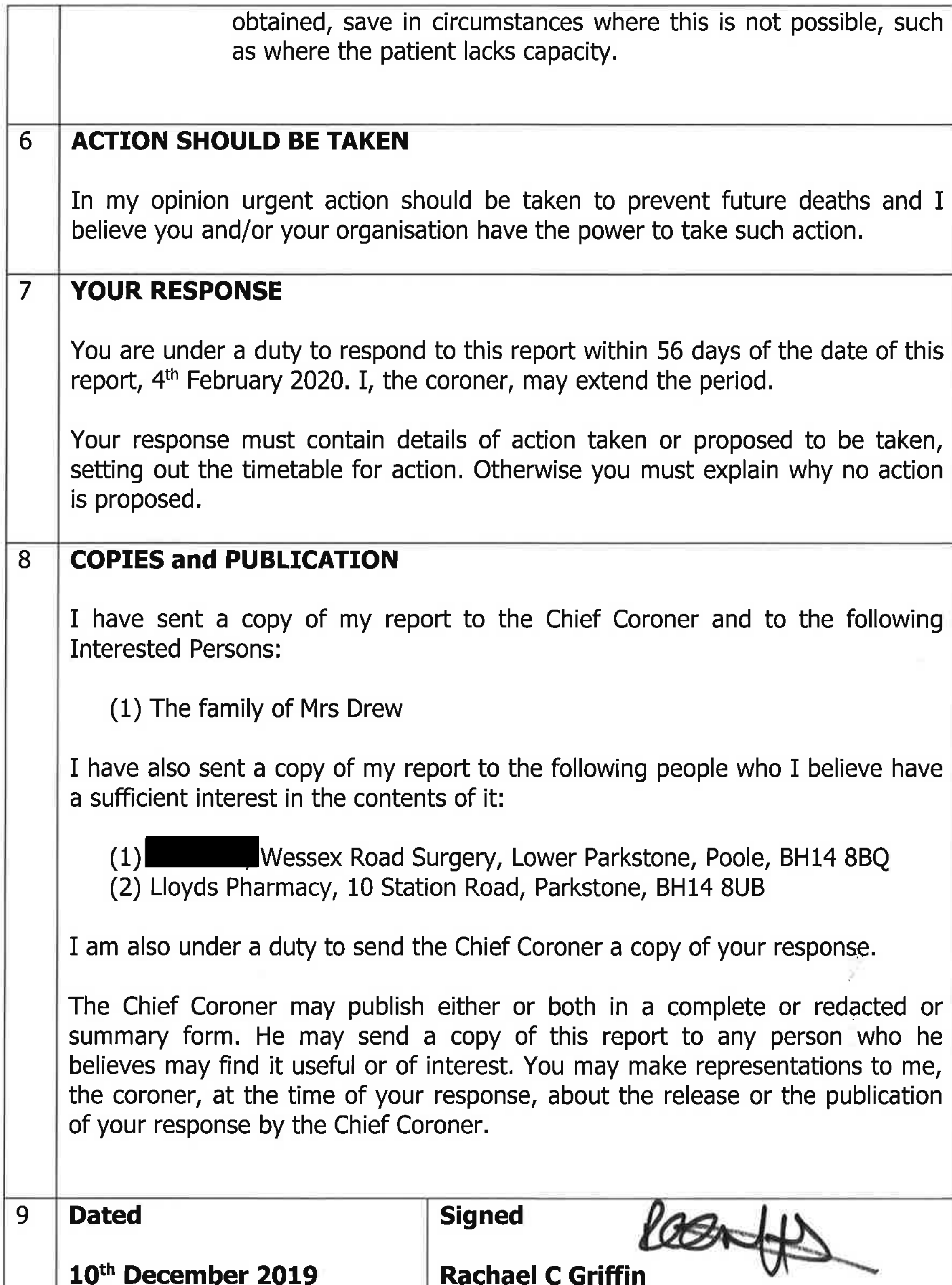
   ii. After her discharge from Hospital Mrs Drew, in addition to her routine prescriptions, began to receive 300ml of Oramorph on repeat prescription. She received these on 27.11.18, 18.12.18, 18.01.19, 24.02.12 and 20.03.19. Evidence given by her family at the Inquest was that she never requested these repeat prescriptions for Oramorph and was surprised to receive them.

   iii. At the Inquest a GP from Wessex Road Surgery, [redacted] gave evidence that the surgery had already identified that this should not have happened and that there had been no formal review at the surgery of the Oramorph prescription to Mrs Drew between 27th November 2018 and 29th March 2019 when she was advised by a GP to stop taking Oramorph. There had been an investigation about this by the Surgery and they were having a meeting on the 5th December 2019 when the processes surrounding this were to be discussed along with the implementation of new guidance regarding Oramorph.

   iv. Evidence however was given by [redacted] that there was concern that Pharmacists seem to request repeat prescriptions for medications without seeking the views of patients. Mrs Drew's family explained at the Inquest that she had not been asked about the continued prescription of Oramorph. There is therefore a risk that patients may have access to medications without requesting it, as occurred with Mrs Drew. It was explained at the Inquest that this is a common concern as it appears to occur regularly.

2. I have concerns with regard to the following:

   i. I am concerned that prescriptions are being requested from GPs by Pharmacists without consultations with patients or having been requested by patients. I would therefore request that consideration be given to providing guidance to all pharmacists in England and Wales that when making a request for a prescription to GPs, they should ensure the wishes of the patient are



	obtained, save in circumstances where this is not possible, such as where the patient lacks capacity.	
6	**ACTION SHOULD BE TAKEN** In my opinion urgent action should be taken to prevent future deaths and I believe you and/or your organisation 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, 4th February 2020. 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: (1) The family of Mrs Drew I have also sent a copy of my report to the following people who I believe have a sufficient interest in the contents of it: (1) , Wessex Road Surgery, Lower Parkstone, Poole, BH14 8BQ (2) Lloyds Pharmacy, 10 Station Road, Parkstone, BH14 8UB I am also under a duty to send the Chief Coroner a copy of your response. The Chief Coroner may publish either or both in a complete or redacted or summary form. He may send a copy of this report to any person who he 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** **10th December 2019**	**Signed** **Rachael C Griffin**