HAVERHILL PHARMACY

Camps Road, Haverhill, CB98HF Tel: 01440706689

RESPONSE TO REGULATION 28: REPORT TO PREVENT FUTURE DEATHS
TO,
Mr Nigel Parsley
Senior Coroner

I am [redacted], pharmacist working at Haverhill Pharmacy

On 8th December 2020, I received a regulation 28 report regarding the death of our patient Mr. Matthew Colin Fitten. Please find below my detailed response regarding the circumstances of death and any future action plans.
Following points will be mentioned in my response.

1) Matthew Fitten death
2) Overview
3) Details of incident

1) Matthew Fitten death:
   Mr. Fitten death was a very shocking and sad news for me and my team. We offer the condolences to Mr. Fitten family.

2) Overview:
   Mr. Matthew Fitten was our patient since August 2018. At the time of his death he was getting following types of treatment.
   a) Methadone for drug dependency from Turning point, Bury ST Edmunds.
   b) Fluoxetine and Olanzapine for mental health from Unity Healthcare, Haverhill.

   He received fluoxetine and Olanzapine from on 14th April and Methadone on 15th April and was found deceased at his home on 17th April 2020.

   3) Investigation done by pharmacy:
   I have done an extensive investigation of this matter and I will explain it below.

a) Sequence of Events:
Following is the detailed history of Mr. Matthew Fitten treatment at pharmacy which may help in further understanding of the case.

- Patient starts taking medicines for mental health in April 2018.

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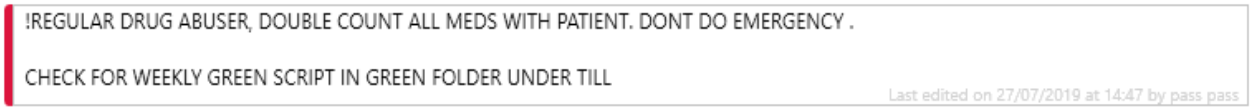
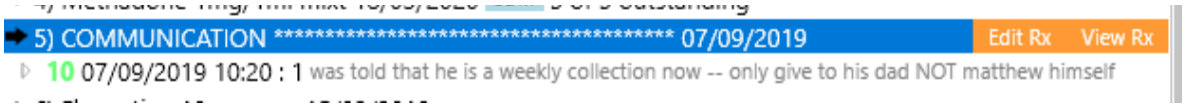
- Patient starts taking methadone in December 2018. Initially he was prescribed daily doses to be picked up at pharmacy and was later moved to three times a week pickup in May 2019.
- Multiple times in June and July 2019, patient tricked pharmacy when he was given weekly tablets by saying he was not given full quantity which was later found to be his way to get more tablets as he used to overdose with more than one day dose in one go. Record of his behavior was made on July 27th 2019 in Patient medication record (PMR). Evidence provided as below.



- On 9th August 2019, patient was given one week supply of Fluoxetine and Olanzapine and between 09/08/2019 and 15/08/2019 patient overdosed himself with the above medicines and the GP refused to issue anymore weekly prescriptions. Patient was issued daily prescriptions to be collected for Fluoxetine and Olanzapine from 16-08/2019 until 03/09/2019. On the day of his first daily pickup, patient abused pharmacist and staff for not providing him weekly medication instead giving him one day dose of Fluoxetine and Olanzapine as per prescription.
- Weekly prescriptions of Olanzapine and fluoxetine resumed on 03/09/2019.
- On 7th September 2019, Patient's father [redacted] visits pharmacy along with Mr Matthew Fitten and spoke to the pharmacist and with consent of Mr. Matthew Fitten takes full responsibility of collecting and administering all medicines to Mr Matthew Fitten. Patient's father was concerned with potential risk of overdose by the patient and wanted pharmacy not to give medicines to the patient but instead always give medicines to him. He assured pharmacist he will always collect medications and put them in a locked cabinet in Matthew's house and he will have the keys for it. It was all done with Matthew Fitten's consent. Record was made on patient's PMR and all staff were informed of it.
- Patient's father starts collecting his medicines from this point. After few months, Matthew himself came to collect his medicines. The pharmacist refused to give medication and Matthew said his father is in car outside. Pharmacist asked to call his father in and his father comes inside pharmacy and confirms he is in car. After that medicines was always collected by Matthew and when questioned about his father he always said he is in car outside. If Matthew's father stopped being involved in collection

and administration of his medications, he never made pharmacist aware of that. Evidence is as below.



- Matthew collects his 2 weeks methadone supply on 15th April 2020 and is found deceased on 17th April 2020.

Matthew's Methadone Collection Profile/Relationship with pharmacy:

- Patient starts taking methadone in December 2018. Initially he was prescribed daily doses to be picked up at pharmacy and was later moved to three times a week pickup in May 2019.
- Patient was very aggressive in his behavior and any delay in medicine resulted in abuse. This was always the case if he used to come in and the medication was not ready.
- Patient never liked to wait and in cases if the methadone was not ready for collection he used to get angry and aggressive and demanded to take methadone in single container rather than individual containers. Sometimes due to lack of time and on patient's demand, he was always given a cup and was very much aware how much dose he needs to take.
- Patient was taking collection doses to take home so was very much aware of his daily dose.
- Due to his habit of collecting medicines from pharmacy and coming back saying we didn't gave him the right quantity, pharmacist always used to double check quantity and daily dose with him (Warning on PMR recorded and provided as evidence).
- On 15th April , Matthew collected 14 days prescription. This was not his first 14 days prescription. He was given his first 14 days prescription on 1st April 2020.

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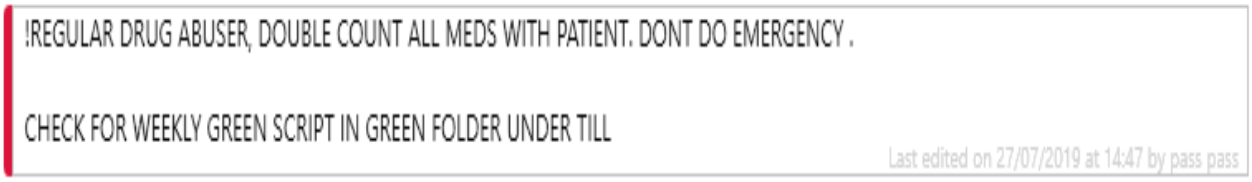
EVIDENCE OF THE PATIENT'S RECORDED BEHAVIOUR ON PMR :

The below record was made on 27/07/2019.



The below record was made on 07/09/2019 as patient overdosed on his medicines and his father asked pharmacy not to give him any medicines and instead his father will collect medicines from that day.

a) Evidence provided to coroner office:

The Evidence provided to coroner office by the patient's representative is the copy of dispensing label which was given to Matthew Fitten. Few months back, Matthew Fitten's father visited the pharmacy and asked he wants to know how much total Methadone was supplied to Matthew Fitten and what was his daily dose and if he can have an evidence of that. The pharmacist prints the copy of the label stored in Matthew PMR and gives it to Matthew's father. The labels provided were the copy of the stored labels and do not give accurate information about the bottles in which Matthew was given methadone. The label stored will gives the right information about the total quantity, daily dose in terms of direction but can be inaccurate in terms of number of bottles. How the prescriptions are stored in PMR and labels generated is explained as below.

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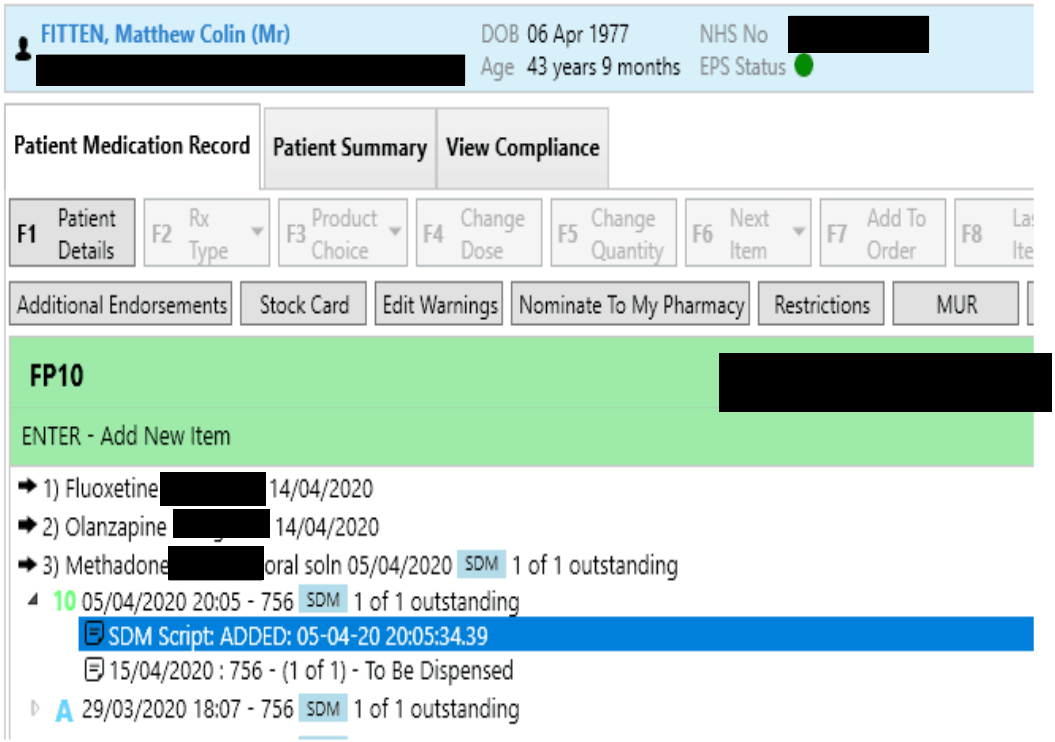
ENTERING PRESCRIPTIONS ON SYSTEM AND PROCESSING OF PRESCRIPTION.

Methadone prescriptions are different that normal GP prescriptions. Turning points posts the prescription to pharmacy well in advance and the staff enters the prescription in software weeks before its due for collection. For example, prescription collected on 15th April was entered in computer on 05th April. However methadone is dispensed the day before or on day of collection. The Labels generated are accurate but computer sometimes calculates odd quantity to be dispensed in individual bottles. However, on time of dispensed the labels are changed manually according to the size of bottles used.

Picture below give the exact date and time when the prescription was entered on the computer and details were stored in PMR. The prescription was entered on system on 05-april-2020 at 08:05pm while the labels were printed on 15th April and also the methadone was made up on 15th April as well. This is around a 10 day gap.



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When a prescription is entered, sometimes the computer automatically creates a quantity which is not the way methadone is dispensed. It does not happen to all of prescriptions. If the person who makes up methadone sees the quantity on label is odd, the change the label to the desired quantity. Please find attached below picture for better understanding.

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Please find below the screenshot of prescription which was entered on 29-march-2020 and patient received it on 1-march-2020. You can see that computer generated a label of [redacted] and [redacted] as can be seen in bottom left corner.

The point of providing this information is that sometimes software automaticallystores a label inside the computer and it is corrected on the day of making the methadone as pharmacist always look at whats been made.

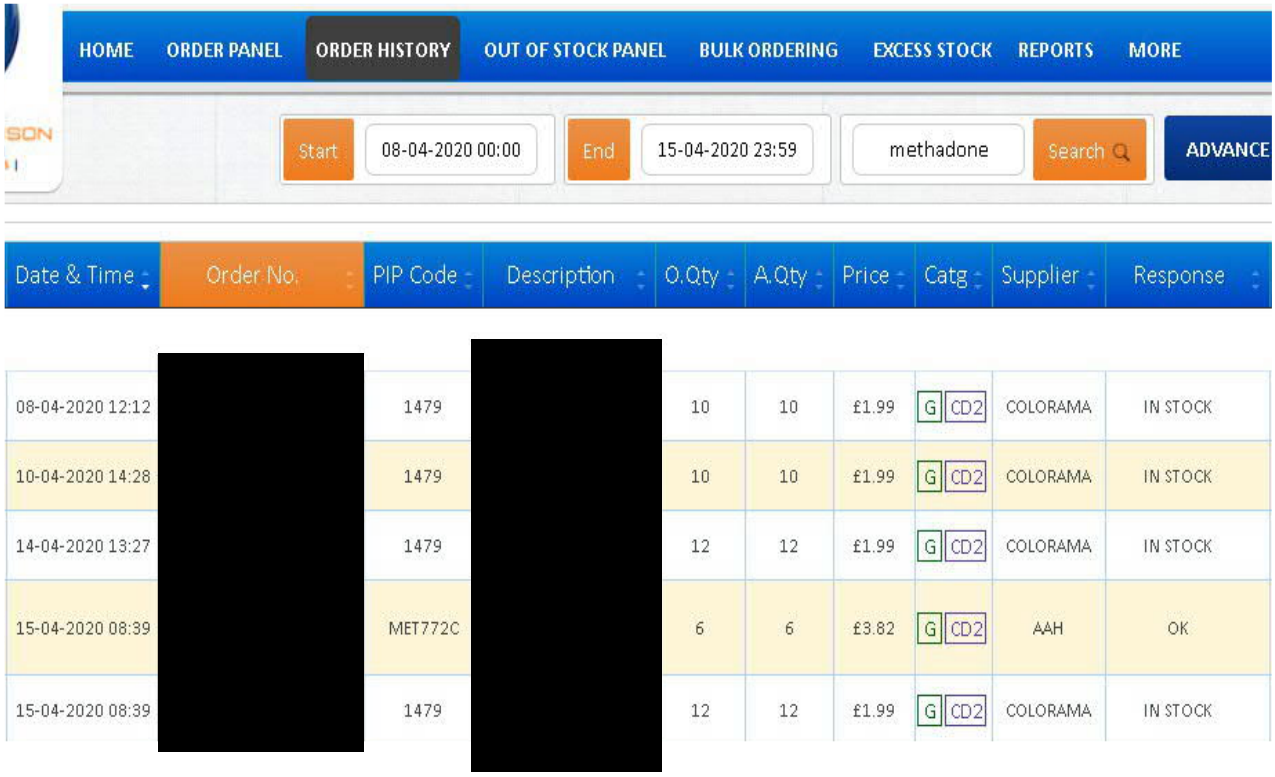
SUPPLY MADE TO THE PATIENT ON 15-APRIL-2020:

The incident happened in April 2020 which was the early times of national lockdown and all mathadone prescriptions were trasnferred to 14 days prescriptions. It was no easy to meet the suuply and demand for the pharmacy due to following issues.

1) We were not able to get the pharmacy supplies from suppliers like paper bags, bottles etc.
2) We were working with reduced amount of staff. 1 staff member left the job as she was extremely vulnerable and other staff member stopped working as her husband was very vulnerable and one staff member resigned in December and we had no replacement for her. So

we were working with around 5 or 6 staff members instead of regular 9. That did put our pharmacy under extreme pressure.

3) Due to lockdown, all the patients called and asked for medicines to be delivered at home. So our deliveries went on from 30-35 a day to over 100 a day which did put us under more pressure.
4) As all patient were given 14 days supply so it was not possible to order methadone in advance and store them in CD cabinets. Pharmacy CD cabinets are small and they cannot store large quantity of methadone bottles. So we were ordering methadone to come on day patients were supposed to come and collect.Please find attached the screenshot of orders of methadone sent for methadone in one week from 08-04-2020 till 15-04-2020. Our normally weekly usage was around 8 bottles of methadone each containing [redacted] liquid but if you check our one week order we ordered around 44 bottles of methadone Sugar mixture. We do not have capacity to store that large quantity and its legal requirement to store it in a controlled drug cabinet. So we were ordering it the day before patients were supposed to collect and make them on the same day of collection. Now that is a huge task especially if you are short staff and have not much supplies. It can be seen that 12 bottles of methadone were ordered on 14-april-2020 for patients to collect on 15-04-2020. Matthew collected on 15-april-2020. As mentioned above he was abusive and never liked to wait. It is possible the methadone came in morning and he came in early morning as well and to avoid abuse and anger, the pharmacy didnt not made in individual bottles. However pharmacist confirms he had the small cups and was always given advice.



Date & Time	Order No.	PIP Code	Description	O.Qty	A.Qty	Price	Catg	Supplier	Response
08-04-2020 12:12	[redacted]	1479	[redacted]	10	10	£1.99	G CD2	COLORAMA	IN STOCK
10-04-2020 14:28		1479		10	10	£1.99	G CD2	COLORAMA	IN STOCK
14-04-2020 13:27		1479		12	12	£1.99	G CD2	COLORAMA	IN STOCK
15-04-2020 08:39		MET772C		6	6	£3.82	G CD2	AAH	OK
15-04-2020 08:39		1479		12	12	£1.99	G CD2	COLORAMA	IN STOCK

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The pharmacist do not remember whether the supply was made in individual bottles or large bottles. The pharmacy always makes methadone in individual bottles but due to lack of supply and staff hours, it is possible the methadone may have not been supplied in individual bottles.

The coroner report was issued in December 2020 which is approximately 8 months gap so pharmacist is unable to remember.

EVIDENCE REQUESTED BY THE PHARMACY:-

In the Coroner's report, the evidence mentioned is the label given by the pharmacy. Matthew's father was informed that this label gives information about the total quantity and daily dose. However as explained, the labels stored in the system may not be accurate in terms of containers used to give methadone and its possible that due to unprecedented circumstances, patients might not be given methadone in individual bottles.
As neither consultation was made with pharmacy nor any information was asked from the pharmacy before issuing of the report, the pharmacist wanted some information to help write the response. The pharmacist requested following information in regards to evidence collected by the Police and forensics fro Matthew Fitten's house. The Coroner's office was unable to provide any information requested as the report was already issued.

The pharmacist requested following information to help compile the response.

1) Upon investigations , what approximate quantity of methadone Mr. Fitten consumed on 17th April that caused the death? Information from toxicology reports or remaining methadone found in bottles from his house.

2) Were any other medicines or chemicals also consumed in overdose beside methadone as he was also on prescription drugs prescribed by GP?

3) Did the police or investigators have pictures of bottles or original bottles as evidence as they will really help me putting my response?

4) Were any methadone found in his locked cabinet or the bottles were in his room or house unlocked?

5) Do we have any figures of other medicines prescribed by GPs? I mean quantity of prescription medicines as he was given one week medication on 14- April ?

6) In my response what does Coroner's office will like the information about as this is first time I will be writing such response. Do you want pharmacy point of view about what actually happened and was supplied on that day and more detailed information about patient as he was

well known to all pharmacy staff. Or you are looking for response only what needs to be done for future.

The pharmacy was provided information to point 6 only.

THE SUPPLY MADE ON 15-04-2020:

Pharmacy do not have any evidence in what size of bottles the supply was made. Also, no evidence or information was provided to the pharmacy by the Coroner's office about the evidence found in Matthew's house.
Although the pharmacy always supply methadone in individual bottles but due to circumstances explained above it is possible that supply was not made in individual bottles.

PREVENTING FUTURE DRUG-RELATED INCIDENTS:

Pharmacy has no information about the bottles used to supply methadone so there are 2 case scenarios.

a) If supply was made in individual bottles:

Haverhill pharmacy always supply methadone in individual bottles. If supply was made in individual bottles, then this was in line with pharmacy normal way of work.

b) If supply was not made in individual bottles:

As explained above that pharmacy may have made supply in bigger bottles than individual dose bottles. This is not the normal practice of the pharmacy. Haverhill pharmacy always ensure safety and wellbeing of patients. April 2020 was an unprecedented time and all pharmacies were dealing with staff issues, supply issues and abuse from patients towards the NHS staff. All these factors may have made the pharmacy supply the methadone not in individual bottles.

Currently we continue to supply methadone in individual containers inline with our normal working procedures. Pharmacy will make aware the prescribers aware in advance if it faces any issue.

[redacted]
Pharmacist Manager
Haverhill Pharmacy