Coroners courts and inquests involving pharmacy

Adam Smith and David Reissner

HEMPSONS

What is a Coroner?

- An ancient jurisdiction
- A legal professional with a duty to investigate certain deaths, where a body lies within that Coroner's area:
  - Violent or unnatural
  - Unknown cause of death
  - Death in custody or otherwise in state detention
- Investigation, potentially including post-mortem
- Inquest

HEMPSONS

What an Inquest is…

- A fact finding inquiry to determine the answers to four questions Section 5(1):
  - Who
  - Where
  - When
  - How
- How – by what means (and, in an Article 2 Inquest, in what circumstances)
- To reach a conclusion as to the death
- To record a medical cause of death
- To record particulars for the purposes of death registration

HEMPSONS

What an Inquest is not…

- A trial (inquisitorial, not adversarial)
- "Interested Persons", not parties
- Blame - no determination to be framed so as to appear to determine civil liability or criminal liability on the part of a named person (s.10(2) Coroners and Justice Act 2009)

HEMPSONS

Interested Person

- IPs listed at Section 47(2), including:
  - May by act or omission have caused or contributed to the death
  - Any other person who the Coroner thinks has sufficient interest
- IP status entitles one to:
  - Disclosure of post-mortem, all relevant statements/reports and documents and a recording of the inquest
  - Representation
  - Participate in the inquest, including questioning witnesses and making submissions to the Coroner on the law (but not the facts – Rule 27, Coroners (Inquests) Rules 2013)

HEMPSONS

Inquests and Pre-Inquest Review Hearings

- A Coroner may hold a Pre-Inquest Review (PIR) to consider case management issues, such as the scope of the inquest, who the IPs are, who the witnesses are, disclosure of evidence and matters for further investigation
- Inquest
  - Evidence may be read (Rule 23) or given orally
  - In person at Court or remotely
  - IPs can make submissions (on the law only)
  - The standard of proof for all conclusions is now the civil standard – on the balance of probabilities (Maughan)

HEMPSONS

Powers of Coroners

- Jurisdiction over deceased's body (including the decision whether or not to order a post-mortem)
- "Schedule 5" powers:
  - To summons an individual to attend to give evidence or produce documents
  - To require a person to provide evidence in the form of a written statement
  - To enter and search land and seize anything from it (with the authority of the Chief Coroner, in certain circumstances)
- Power to impose a fine for a failure, without reasonable excuse, to comply with a "Schedule 5 Notice"

HEMPSONS

Practicalities

- Do not assume criticism simply because contacted by the Coroner's office
- Good rapport (if possible) with the Coroner's Officer will help you
- Tactical consideration of whether you wish to be an IP (if you have a choice). If you are an IP, ask:
  - Who the other IPs are
  - Who their representatives are
  - Who the witnesses are
  - Request disclosure of PM and all statements
  - Ask if there has been / will be a PIR?
  - Request a copy of PIR / case management directions

HEMPSONS

Practicalities

- Statements to the Coroner
  - Ask if there is anything specific the Coroner wishes to be addressed
  - Keep it factual – what you did and why you did it
  - Submit it in good time – a sufficiently detailed, helpful statement provided in good time may avoid your attendance at the inquest (it may instead be read under Rule 23)
  - Legal advice – especially if you have been made an IP or consider yourself at risk of criticism (possibility of GPhC)
- Provision of records – if requested, provide full records promptly

HEMPSONS

Practicalities

- Attendance at the Inquest
  - Importance of compliance with a summons (Contempt of Court / fine by the Coroner)
  - Attendance may be in person or online, subject to the Coroner
  - Treat online attendance as though you were sat in Court – it is still a Court and the same rules and expectations apply
  - There should not be anybody else in the room with you when you give evidence
  - Treat the Inquest like an extension of the funeral
  - No appeal – challenge by way of judicial review

HEMPSONS

Practicalities

- Useful documents:
  - The Coroners and Justice Act 2009
  - The Coroners (Inquests) Rules 2013
  - The Coroners (Investigations) Regulations 2013
  - Chief Coroner's Guidance and Law Sheets (Chief Coroner's website)

HEMPSONS

Prevention of Future Deaths

- Coroner must issue a "PFD / Reg 28" report to a person who the Coroner believes has power to take action if:
  - Concern is revealed by the investigation that circumstances creating a risk of other deaths will occur or continue in future; and
  - In Coroner's opinion, action should be taken to prevent / eliminate / reduce the risk

  (Regulation 28 and Paragraph 7, Schedule 5 of the Act)
- Ancillary to the four questions – Coroner may hear evidence separately on PFD issues
- 56 days to respond
- Report and response on Chief Coroner's website
- Often perceived by recipients as punitive, but not necessarily so

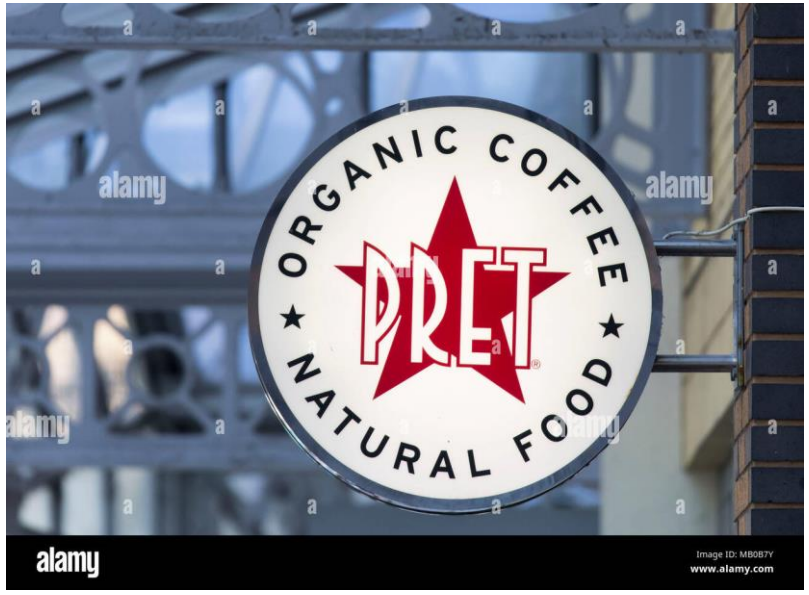
“Bungling chemist”

Mirror

- Chemist's fatal dose of morphine kills grandfather
- Coroner - Anthony Peckham “received and ingested morphine sulphate 10 times as strong and died from the effects”.
- Coroner criticised pharmacist’s "inclination to place the responsibility" at his assistant's door as being "entirely unacceptable, reprehensible and a prima facie breach of his professional obligations".
- Pharmacist did not agree.
- RPSGB said he represented "an unwarranted risk of harm to patients"

the PHARMACEUTICAL JOURNAL 12 October 2018

- Baguette from Pret - 15-year-old Natasha Ednan-Laperouse
- Coroner calls on MHRA to take action over ‘inherently unsafe’ EpiPen
- EpiPen needle length and inadequate adrenaline dosage “raised serious concerns about the injector’s safety”.



the
PHARMACEUTICAL JOURNAL –
1 September 2020

NICE updates anaphylaxis guidance to ensure patients carry two adrenaline injectors in response to coroner's report

NICE National Institute for Health and Care Excellence

Elizabeth Lee and Carmel Sheller

Who collected the oramorph?

- Helen Spicer - regular medicines included oramorph (oral morphine)
- 1 October 2018, admitted to Royal Cornwall Hospital
- 2 October 2018, given oramorph in hospital
- 2 October 2018, prescription presented to a community pharmacy
- 4 October 2018, consumed significant quantity of oramorph
- 4 October 2018 died from unintentional overdose
- Coroner's concerns included:
  - Absence of restrictions on possession and administration
  - No requirement for oramorph to be signed for when collected from a pharmacy

Reporting requirement for CDs?

- Michael Lobban – collected 68 methadone tablets 5mg prescribed for him
- Died of overdose
- One week later, pharmacy routine CD check found 51 tablets were missing
- Coroner's concerns included:
  - Lack of steps to contact methadone 5mg patients when discrepancy discovered
  - CD audit at pharmacy did not involve checking contents of boxes
  - No requirement to notify GPhC of discrepancy
  - No sanctions for mislaying CDs

Pharmacies requesting repeats

- Brenda Drew – repeat prescriptions for Oramorph for pain relief
- 29 March 2019 - GP advised her to stop taking it
- 6 April 2019 – found dead with fatal level of morphine in blood
- Between 29 March and 6 April - pharmacy requested repeat prescription

Pharmaceutical Journal

- **8 April 2021 - Coroner's report recommends tightening regulation around forms of codeine and morphine**
- **PJ 2 September 2021 - Government fails to respond to calls for tighter controls after liquid morphine deaths**
- Exclusive: Coroners in England and Wales have investigated the deaths of thirteen people after overdoses involving liquid morphine since 2013, with some patients known to "swig" from the bottle to obtain pain relief.
- **18 February 2022 Government advisory body on controlled drugs reviewing safety of liquid morphine**
- Exclusive: Following the receipt of two regulation 28 notices, the Advisory Council on the Misuse of Drugs' technical committee is reviewing information on serious patient safety incidents involving morphine oral solutions.

the
PHARMACEUTICAL JOURNAL 2 September 2021

Medicines safety

02 September 2021

By **Carolyn Wickware**

Government fails to respond to calls for tighter controls after liquid morphine deaths

Exclusive: Coroners in England and Wales have investigated the deaths of thirteen people after overdoses involving liquid morphine since 2013, with some patients known to "swig" from the bottle to obtain pain relief.

Morphine sulphate solution (Oramorph; Boehringer Ingelheim) is used to relieve severe pain such as that associated with cancer, severe injury and surgery

DR P MARAZZI / SCIENCE PHOTO LIBRARY

Medicines safety

20 March 2023

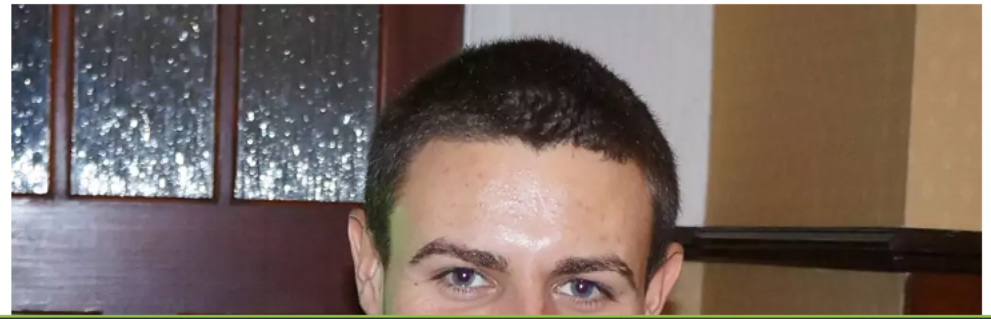
By **Keith Houghton**

'Pandemic of tragedy': how the availability of drugs online led to the death of a 24-year-old

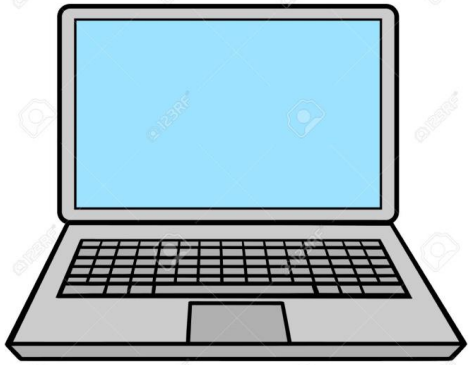
A father recounts how the death of his son Jason Houghton could have been prevented with tighter controls around the availability of drugs online.

Copy link to page

Download PDF



A database for prescribers?



- Debbie Headspeath - codeine dependent
- Prescriptions, bought OTC and online (from 16 suppliers)
- Coroner's concerns included:
  - No database to inform prescribers what was prescribed elsewhere
  - Patients opted out of sharing information with regular GP
  - GPhC's guidance was not mandatory
  - Use of overseas prescribers avoided regulation by CQC

DHSC said it was working with regulators to close loopholes

Online pharmacies

- Ania Sohail – 22
- Detained under Mental Health Act
- Ordered Propranolol online from 4 pharmacies
- Suicide
- Coroner's concerns:
  - Whilst each individual pharmacy had in-house checks to safeguard against over-prescribing, no integrated system alerting to prescriptions dispensed elsewhere
  - No requirement for online pharmacies to share information with GP in the absence of consent
  - Lack of information-sharing = risk of prescribing something contraindicated by a medication dispensed elsewhere

Medicines safety

30 March 2023

By **Carolyn Wickware**

Government warned repeatedly to better regulate supply of drugs online after series of deaths

Exclusive: Analysis of coroner's reports has revealed a decade-long pattern of deaths caused by overdoses from drugs supplied online, accompanied by warnings to the government that more may die without tighter restrictions.

Copy link to page

Download PDF

Any questions?