Summary of Regulation 28 Report to Prevent Future death: Juanita Nti (died 9/9/20)

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This is a brief summary of the regulation 28 coroners report into the death of Juanita Nti from which you can review the coroner recommendations to health care and consider whether there are changes you could implement in your local NHS trust to address them

Clinical summary

4-month-old girl

- Townes-Brocks syndrome with tracheal stenosis & complex congenital heart disease which was not treatable.

Events surrounding death

- Juanita was overdosed with morphine -> respiratory arrest at home
- Discharged with 120 mcg morphine which symptom care dispensed as 100mcg/ml solution.
- GP re-e-prescribes 10mg/5mls solution as no alternative on EMIS but also free-texted 100mcg/ml, 120mcg 6hrly
- Unclear prescription not identified by pharmacy
- Jaunita received 3mg instead of intended 150mcg

Coroner's Recommendations

- Local partnership between hospital, GP and pharmacy to revise repeat prescription policy
- Improved standard operating procedures
- Revised paediatric formulary
- Overall improvement in paediatric prescribing

Key Themes

- Inadequacies in communication between care providers, and with carers
- Safety issues in electronic prescribing & prescribing of controlled drugs
- Prescribing errors when there are differing drug concentrations available

Local Improvement suggestions from this report

- Education program to work through resources on MedsIQ
- Review morphine prescribing success & failures, identify what works in getting morphine prescriptions and administration right every time then embed this.
- Empower the carers: For children discharged with morphine, ensure caregivers understand the re-prescribing risks with repeat prescriptions of morphine and are empowered to ask questions.

For full information visit:
https://www.judiciary.uk/prevention-of-future-death-reports/juanita-nti-prevention-of-future-deaths-report/
or follow the QR code