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Russell-Cooke represents charity at an inquest into Warfarin overdose death

Summary of background

Russell-Cooke was instructed to act on behalf of a social care charity which provides accommodation and support services for people with disabilities. The inquest related to the death of a resident at one of the charity's care homes.

The deceased had been taking Warfarin for many years and was prescribed a regular dose of 2.5mg per day at the time of his death. His 'INR' level, which measured how long it took his blood to form a clot and determined the effect of the Warfarin, was regularly checked by the deceased's GP. The deceased's 'target' INR level was 2.5.

The Warfarin which the deceased was prescribed came in a sodium solution. The concentration of the solution was supposed to be 1mg of Warfarin per 5ml of solution. In order to receive his prescribed dose of 2.5mg of Warfarin per day, the deceased would therefore take 12.5ml of the Warfarin solution.

The deceased's prescriptions were processed by a pharmacy in his local area, which would enter the prescription onto a computer, print off the dispensary labels (showing the prescribed dose and the strength) and place these on the appropriate medication. The labelled medication was supposed to be checked and signed by two pharmacy employees before this was given to the patient, or in this instance sent out to the care home.

A few days prior to his death, the pharmacy dispensed the deceased's medication and sent this to the care home. Unbeknownst to the deceased and to staff at the care home, the pharmacy had mistakenly dispensed a stronger concentration of Warfarin solution than it ought to have done. This contained 5mg of Warfarin in every 5ml of solution. As a result, taking his normal 12.5ml of solution per day meant that the deceased was receiving a daily dose of Warfarin which was five times the prescribed dose.

After having taken the stronger medication for some days, the deceased started to show signs of blood in his urine, in relation to which he received medical attention. Antibiotics did not resolve the problem and it was decided by his GP that he should be referred to hospital.

Following his admission to hospital, it was found that the deceased's INR level was grossly elevated, being at the top of the scale of measurement. He was given Vitamin K to try to reverse the action of the Warfarin and his INR reduced to an acceptable level. However, after a few days the deceased's condition deteriorated and he was found to have suffered a large brain haemorrhage. He passed away the following day.

The inquest

The Coroner obtained medical evidence regarding the cause of the death and concluded that the deceased would not have been likely to suffer the brain haemorrhage but for the excessive dose of Warfarin he had been taking for a period of approximately eight or nine days.

The Coroner heard evidence from witnesses at the inquest regarding the chain of events leading up to the death and how the mistake with the medication had come about. Issues were raised regarding the processes being followed within the pharmacy and the systems for checking medication into the care home run by Russell-Cooke's client.

Evidence provided to the Coroner confirmed that that the dispenser and the pharmacist involved in 'checking' the deceased's last Warfarin prescription had failed to confirm that the medication was of the correct strength. The dispenser had also mistakenly applied labels to the medication boxes, stating that the medication was the usual 1mg in 5ml solution when it was in fact 5mg in 5ml. The pharmacist had failed to pick up on this.

The issue so far as the care home was concerned was that its staff were supposed to check that any medication received into the home matched the prescription of the resident, according to that resident's 'Medication Administration Record'. Here, the label on the box of medication was misleading, in that it stated that the box contained the deceased's usual strength of Warfarin solution, whereas in fact it was five times stronger.

However, it was acknowledged by the care home charity that, in order to try to guard against these types of events in future, staff should check not only the pharmacy label but also the manufacturer's label on the medication, to ensure that these match. This was reflected in changes in the care home's medication policy, which were implemented after the death. No criticism was made of the charity in the Coroner's conclusion at the inquest.

The pharmacist involved in these events was prosecuted under the Medicines Act 1968 and was dismissed by his employers following a disciplinary hearing. At the time of the inquest, he was under a temporary suspension, preventing him from practising as a pharmacist.

If you or your organisation wish to seek legal advice in relation to an inquest, or the types of issues referred to in this report please do not hesitate to contact a member of our team.

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