

SPS Medication Safety Update September 2026

Recent critical patient safety alerts,
reports, and publications

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The first stop for professional medicines advice

Date of presentation

30/9/26

Patient Safety Alerts

Nil relevant in September

Prevention of Future Death Reports (Regulation 28)

[Tia Birkitt: 2026-0348](#)

Propranolol overdose

Tia, aged 20, died after taking a substantial overdose of prescribed propranolol at home. She received emergency treatment and was taken to hospital but was unconscious on arrival and resuscitation attempts were unsuccessful.

The Coroner's concerns related to mental health referral processes and care for patients with autism/communication difficulties rather than medication safety; but this case highlights that patients are coming to harm due to prescribed propranolol.

- **Does your organisation have processes to consider the risks associated with prescribing and supplying medicines that may be harmful in overdose to patients at risk of self-harm, including whether quantities supplied should be limited where clinically appropriate?**

Prevention of Future Death Reports (Regulation 28)

[Tia Birkitt: 2026-0348](#)

Royal Colleges call for review of propranolol safety information

The Royal College of Pharmacy and the Royal College of Physicians Medicines Safety Joint Working Group, in collaboration with the National Poisons Information Service, has written to the MHRA asking them to review propranolol's indication and safety information for generalised anxiety disorder (GAD), particularly in relation to overdose, self-harm and suicide risk.

Key concerns:

- There is no proven evidence that propranolol is effective in the treatment of GAD.
- Propranolol poisoning is life-threatening, difficult to treat & associated with a significant number of deaths.
- Prescribing for propranolol in general practice is increasing, partly due to its perceived safety.
- Patients at increased risk of overdose, including those taking antidepressants or with a history of overdose, continue to be prescribed propranolol.

Consider overdose and self-harm risk when prescribing, reviewing or supplying propranolol, particularly for anxiety, and consider safer alternatives where appropriate.

Prevention of Future Death Reports (Regulation 28)

[Naeem Ahmed: 2026-0319](#)

Denaturing CDs

Naeem, a Consultant Anaesthetist, died after working an extended run of 11 consecutive night shifts. He was found unresponsive in a hospital rest room on after failing to attend handover, and his death was attributed to alcohol and unnamed drugs. The source of the drugs could not be determined.

The Coroner highlighted concerns that the Trust's practice of disposing of small volumes of medicines (e.g. post-surgery) into sharps bins created a risk that potentially fatal drugs could be retrieved; the Trust has since introduced denaturing gel in sharps bins to immediately render discarded medicines unusable.

- **Does your organisation have a secure process for disposing of residual medicines, particularly CDs, that prevents discarded medications from being accessed or retrieved from sharps bins?**

Related SPS series: [Managing Controlled Drugs \(CD\) waste](#)

Prevention of Future Death Reports (Regulation 28)

[Suzanne Fredericks: 2026-0331](#)

Medicines monitoring

Suzanne, a 41-year-old liver transplant recipient with complex liver and kidney disease, died in hospital. Whilst it was determined that she died from natural causes, evidence heard at the inquest indicated that delays in obtaining laboratory results may have affected clinicians' ability to make timely treatment decisions regarding her complex immunosuppressant therapy.

The Coroner highlighted concerns that clinicians caring for transplant patients in non-specialist hospitals may not have access to sufficiently up-to-date blood test results to support timely clinical decision-making; the Coroner noted that delays in the collection, processing, and reporting of laboratory results could adversely affect patient outcomes and potentially contribute to future deaths.

- **Does your organisation ensure that blood test results required to guide prescribing and monitoring of immunosuppressive and other high-risk medicines are available without delay to support timely clinical decision-making?**

Related SPS pages: [Safe management of therapeutic drug monitoring](#) & [Medicines Monitoring Tool](#)

Prevention of Future Death Reports (Regulation 28)

[June Turner: 2026-0351](#)

Anaphylaxis to medication

June, aged 77, died following anaphylaxis caused by a steroid injection administered into her shoulder at her GP surgery. Ten minutes after the injection, she returned to the surgery with shortness of breath, rapidly deteriorated and became peri-arrest. She died in hospital 16 days later.

The Coroner highlighted concern that, while Department of Health guidance addresses the risk of severe life-threatening reactions following immunisation, there is no equivalent guidance regarding the risk following steroid injections, despite the potential for severe anaphylaxis.

- **Are staff administering medicines appropriately trained and equipped to respond to a severe medication reaction?**

Prevention of Future Death Reports (Regulation 28)

Catherine Kirkham: 2026-0347

Catherine, aged 82, died from complications of tetanus after several healthcare attendances following a fall that caused leg wounds. Opportunities to identify her vaccination status and diagnose and treat tetanus were missed, including when she presented with lockjaw and swallowing difficulties.

The Coroner highlighted concerns about difficulties accessing vaccination records, inadequate clinical documentation, prescribing oral antibiotics despite swallowing difficulties, and failures across primary and secondary care to identify and clearly communicate suspected tetanus.

- **This case highlighted the difficulties in assessing vaccination status in healthcare records.**
- **Does your organisation ensure patients with swallowing difficulties are assessed before oral medicines are prescribed, with alternative routes considered where appropriate?**

Related SPS series: [Swallowing difficulties](#)

Prevention of Future Death Reports (Regulation 28)

Alison Thomas: 2026-0344

Medication overdose

Alison, aged 58, died after taking a large quantity of prescribed and OTC medicines. She had a history of POM misuse and overdose, and her codeine supply had been restricted to weekly prescriptions; however, she obtained ~1 month's supply, alongside gabapentin, oxycodone and oral morphine, after reporting plans to travel abroad; she was also prescribed high-dose temazepam.

The Coroner highlighted concerns about the absence of policies for long-term opioids, gabapentinoids and benzodiazepines; inadequate safeguards when supplying larger quantities to patients at known risk of misuse or self-harm; and a lack of systems to identify and review patients prescribed multiple medicines associated with respiratory depression (Alison was diagnosed with COPD).

- **Does your organisation have policies for the safe prescribing, review and monitoring of long-term opioids, gabapentinoids and benzodiazepines, including patients prescribed these medicines in combination?**
- **Does your organisation ensure requests for larger-than-usual quantities of medicines are appropriately risk-assessed, especially where prescribing or supply restrictions are in place due to misuse or self-harm risk?**

Prevention of Future Death Reports (Regulation 28)

[Alison Thomas: 2026-0344](#)

For information

The Coroner highlighted the following NICE guidelines:

- [Medicines associated with dependence or withdrawal symptoms: safe prescribing and withdrawal management for adults \(NG215\)](#)
- [Chronic pain \(primary and secondary\) in over 16s: assessment of all chronic pain and management of chronic primary pain \(NG193\)](#)

And highlighted that there are relevant Drug Safety Updates, including:

- [Gabapentin \(Neurontin\): risk of severe respiratory depression](#)
- [Pregabalin \(Lyrica\): reports of severe respiratory depression](#)
- [Pregabalin \(Lyrica\), gabapentin \(Neurontin\) and risk of abuse and dependence](#)
- [Benzodiazepines and opioids: reminder of risk of potentially fatal respiratory depression](#)
- [Opioids: risk of dependence and addiction](#)

Prevention of Future Death Reports (Regulation 28)

[Bethany Hewitt: 2026-0343](#)

Antidepressant monitoring

Bethany, aged 34, died while awaiting an ADHD diagnostic assessment, having been referred 3 years earlier. During this period, her mental health deteriorated. In a Nov 2025 GP appointment, she reported worsening symptoms, anxiety and was noted to be tearful. She was started on sertraline 25mg daily and advised about the potential for increased suicidal ideation, but no follow-up appointment was arranged. In Feb 2026, she subsequently disclosed suicidal thoughts on a questionnaire, but no further follow-up was planned after GP assessment.

The Coroner highlighted concerns about the lack of follow-up and monitoring following MH consultations, alongside prolonged waits for ADHD assessment and missed opportunities to identify deterioration in her mental health and escalate care.

- **Does your organisation have processes to ensure appropriate follow-up and monitoring when antidepressants are initiated, particularly in patients experiencing suicidal thoughts or worsening MH?**

Prevention of Future Death Reports (Regulation 28)

[Isabelle Bridie Sapherson-Moralee: 2026-0339](#)

Pain management with illicit substance misuse

Isabelle, aged 23, died from respiratory depression due to combined severe morphine and gabapentin toxicity, with biliary sepsis from ketamine-related chronic liver disease contributing. She was very underweight and had chronic pain associated with long-term ketamine use, for which she was prescribed morphine and gabapentin; there was no evidence she intentionally misused these medicines. Isabelle remained engaged with drug treatment services and her GP but was unable to abstain from using ketamine.

The Coroner highlighted concerns about the absence of guidance to support safe analgesic prescribing where ketamine use continues, including consideration of interactions and the risk of unintended overdose.

- **Does your organisation have processes to support the safe prescribing and review of analgesics in patients who continue to use illicit substances?**
- **Are patients prescribed high-risk analgesics given clear information about the potential harms of combining their medicines with illicit substances, including the risk of unintended overdose?**

Manufacturer RMM

Fingolimod – various Risk Minimisation Materials

A patient, parent and caregiver guide is available, detailing key points about fingolimod treatment, as is a prescriber checklist. A pregnancy-specific patient reminder card can also be downloaded, which advises patients of the risks and what to do in case of pregnancy.

Simponi (golimumab) – Patient card

A patient alert card is now available, covering important safety information such as pregnancy & vaccinations, infections, and TB screening.

Alecensa (alectinib): Guidance for management of severe hypertriglyceridaemia

Hypertriglyceridaemia, including severe and life-threatening events, has been identified as a new adverse drug reaction of Alecensa. Advice is given on monitoring triglycerides and for development of pancreatitis, as well as management.

Risk Minimisation Materials for Tuyory (tocilizumab)

Patient Card contains important safety information that patients or parents/guardians need to be aware of before, during and after treatment, including the risk of a new or worsening infection, complications of diverticulitis, hepatotoxicity and suppression of CRP levels.

Manufacturer RMM

[Nplate \(romiplostim\): Home Administration Training - Patient DVD](#)

A DVD is available for patients, in order to help them with the process of preparation and self-administration of the correct dose of romiplostim at home. Advice is given on how to request a copy of the DVD.

[Lamzede \(velmanase alfa\) – Home Infusion Diary](#)

Diary designed to record administration of velmanase alfa. Includes space for key healthcare professional contact details and guidance on action to take in the event of an infusion-associated reactions, with reporting information provided on the front and back covers.

[Asthalin 100 micrograms Inhaler \(Salbutamol Sulphate\) – Clarification of paediatric dosing information on the outer carton](#)

Letter to inform healthcare professionals of inconsistency between the age-related information currently printed on the outer carton ('for adults and children over 12 years of age') and the approved UK SmPC and PIL (includes dosing recommendations for children aged 4-11 years).

MHRA Drug Safety Update

Filters should be used during the administration of Parenteral Nutrition for patients in all care settings

Administration of parenteral nutrition (PN) without a filter has been associated with several adverse incidents including an embolism which resulted in a fatal outcome; advice for healthcare professionals:

- ensure all PN solutions are administered using a filter with a pore size no larger than 1.2µm
- where the solution is aqueous/lipid free, it is good practice to use a filter with a pore size of 0.2µm during administration
- filters and administration sets should be changed with each new PN container, based on the PN shelf-life, local infection control policies, and filter shelf-life
- use of filters integrated into administration sets are preferred but add-on filters are a suitable alternative providing infection control guidelines are followed
- report suspected adverse reactions associated with PN on a [Yellow Card](#).

Direct HCP communications

The complete [MHRA Safety Roundup](#) is available [here](#).

[Fostair® 200/6 microgram pressurised metered-dose inhaler \(pMDI\) - Supply of batches without a dose counter](#)

Letter containing actions for HCPs to take if prescribing or dispensing a Fostair inhaler without a dose counter.

[Finasteride and dutasteride - Updated safety warnings for psychiatric side effects and sexual dysfunction](#)

Letter advising of updated safety warnings for psychiatric side effects and sexual dysfunction

[Ventolin® Solution for Intravenous Infusion 5mg in 5ml \(Salbutamol Sulfate\): Interim Supply of Portuguese Stock to Mitigate Supply Disruption](#)

Letter containing information on the Portuguese product; it advises to ensure all relevant staff are made aware of the contents of this letter and that the information is shared with patients where appropriate.

[Fabrazyme 5mg powder for concentrate for solution for infusion \(agalsidase beta\), Fabrazyme 35mg powder for concentrate for solution for infusion \(agalsidase beta\), Nexviadyme ▼ 100mg powder for concentrate for solution for infusion \(avalglucosidase alfa\) – intermittent supply distribution](#)

Letter providing more information on the supply disruption, expected to continue at least until the end of the year.

Direct HCP communications

The complete [MHRA Safety Roundup](#) is available [here](#).

ChloraPrep 2% w/v / 70% v/v cutaneous solution 1.5 mL Frepp presentation, chlorhexidine digluconate / isopropyl alcohol - Interim Supply of US Stock to Mitigate Supply Disruption in the UK

Letter containing information on the US product, including images; it advises to ensure all relevant staff are made aware of the contents of this letter and that the information is shared with patients where appropriate.

ChloraPrep 2% w/v / 70% v/v impregnated cutaneous swab (1.75 mL single swab sticks, supplied in packs of 48 units), chlorhexidine digluconate / isopropyl alcohol - Interim Supply of US Stock to Mitigate Supply Disruption in the UK

Letter containing information on the US product, including images; it advises to ensure all relevant staff are made aware of the contents of this letter and that the information is shared with patients where appropriate.

Medication Supply Notifications

Recent medicine shortages and discontinuations are available via: the [SPS Medicines Supply Tool](#) (registration required to access).

Medicine Supply Notification: Moviprep® and Plenvu® oral powder sachets

Moviprep sachets are in limited supply until January 2027. Plenvu remains available but may experience intermittent delivery delays. Other bowel preparations are available but have limited capacity to meet increased demand.

NHS Provider Trust pharmacy procurement teams should:

- Review local bowel preparation stock and centralise ward stock where appropriate.
- Liaise with clinical teams to switch to Plenvu where clinically appropriate.
- Order Moviprep & Plenvu conservatively, in line with projected demand and wholesaler restrictions.
- Work with clinical and diagnostic leads to ensure affected clinical & diagnostic areas are aware of the shortage and mitigations, and review/update PGDs as required.

Where these measures are unsuitable, consider alternative bowel preparations, taking account of renal function, contraindications/cautions and excipient intolerance, and provide patients with appropriate preparation and administration instructions.

National guidance, publications & resources

Independent report: Thirlwall Inquiry report

Report and recommendations of the public inquiry established to examine the events at the Countess of Chester Hospital from 2015 to 2018.

Relevant recommendation:

Recommendation 2 - Insulin

1. Digital devices should be used to restrict access of insulin to authorised people and record access to insulin storage units. By 31 March 2027, all neonatal units must meet the expected requirements for access control and storage of insulin set out in the NHS England [Getting It Right First Time guide GIRFT Neonatology: Guide to safe insulin use](#).
2. Until access to insulin requires the provision of biometric data, each Trust should install CCTV cameras focused on storage fridges, cupboards or units. The cameras should store recordings for at least 28 days.
3. The GIRFT Laboratory Handling of Insulin Requests in the Investigation of Hypoglycaemia guidance for the testing and reporting of insulin and C-peptide results, issued in October 2025, must be made mandatory and of national application.

National guidance, publications & resources

UK multidisciplinary Consensus Document – Safe Management of Hazardous Medicinal Products in UK Healthcare Settings

Document aims to support a more consistent UK approach to identification, occupational risk assessment and safe management of hazardous medicinal products. It highlights current variation in practice, sets out several recommendations, and identifies priorities for future work.

Aesthetic practice and pharmacy

The Royal College of Pharmacy has published an updated position on aesthetic practice, setting out professional, legal and regulatory expectations for pharmacists providing non-surgical cosmetic procedures, including demonstrating competence for safe, person-centred care.

National guidance, publications & resources

[HSSIB: Mental health crisis care: care of patients in emergency departments](#)

Second of two HSSIB investigation reports on crisis care in emergency departments, focusing on people experiencing a mental health crisis. These patients are around twice as likely as others to spend more than 12 hours in the emergency department. Two safety recommendations are made.

[HSSIB: Launch of Knowledge Exchange as demand for investigation expertise grows](#)

The [Knowledge Exchange](#) is a central repository for anyone involved in patient safety investigations. It brings together learning resources and practical guidance to support high-quality, professional, compassionate, and trauma-informed investigations.

Resources will continue to be developed and expanded over the coming years.

Related SPS series: [Responding to medication incidents](#)

National guidance, publications & resources

MHRA concludes review of Avacopan Vifor (previously known as Tavneos) following reassessment of benefit-risk balance

- MHRA review concludes available evidence no longer supports positive benefit-risk balance, as the pivotal study can no longer be relied upon.
- Its supply to new patients has been suspended; supply to existing patients will be permitted during a 6-month managed withdrawal period.
- Patients taking Avacopan Vifor should not stop treatment without first discussing their care with their specialist healthcare professional.
- Existing risk minimisation advice in the product information continues to apply, including monitoring LFTs, for which the recommended testing frequency was recently increased, as well as monitoring WBC count and assessing patients for any serious infections.

(Last month – Dear Healthcare Professional letter: [Avacopan Vifor, previously known as Tavneos \(avacopan\) ▼ : Updated requirements for liver monitoring and stopping rules to mitigate risk of drug-induced liver injury and vanishing bile duct syndrome](#))

Specialist Pharmacy Service

A patient-centred approach to improving medication safety

- Patient, carer and family involvement is central to medication safety.
- The patient voice helps identify risks and understand diverse perspectives and lived experiences.
- Meaningful patient involvement supports engagement, accountability and continuous improvement.
- The article outlines practical approaches to involving patients in medication safety, including co-production, Patient Safety Partners, PSIRF investigations, focus groups, surveys, and collaboration with existing patient networks.

Specialist Pharmacy Service

[Adverse drug reactions: resources to support clinical decisions](#)

The article lists recommended authoritative resources for healthcare professionals researching medicine side-effects, alongside training modules, on approaching adverse-effect medicine enquiries.

[Dealing with temperature excursions video](#)

This article forms part of a series: Understanding why temperature management is important for medicines storage. This 40-minute video was originally created for an SPSQA lunchtime webinar and is aimed at healthcare professionals working in pharmacies and clinical areas.