Dear Sir/Madam

Thank you for your Freedom of Information request concerning drugs gone missing.

For the years 2011, 2012, 2013 and to date in 2014 please provide the following information:

1. How many drugs went missing each year and what the annual cost was to the trust with regards to the unaccounted for medication/drugs.

Please see details in table below which provides details of reported missing drugs. It has been estimated that the approximate value of those drugs reported as missing is £20.

2. Please detail the types and categories of all drugs that went missing for each year and specify the amount/volume for each category/type.

Please see details in table below.

3. Please list for each year, when each drug went missing, whether it was subsequently found, how it is thought to have gone missing (eg lost or stolen), from what hospital it went missing or was stolen from, what action was taken (eg police informed, trust inquiry) and who the perpetrator was (eg staff member, patient or member of the public).

Please see details in table below. Where required i.e. for controlled drugs the police will have been notified via the Local Intelligence Network.

4. Please supply copies of any reports or incident logs referencing the missing drugs in each year and any alerts to staff members about the missing or stolen drugs.

Please see details in table below. All pharmacy staff were alerted to/briefed following drugs being reported missing – Standard Operating Procedures & systems are updated accordingly when required.

Updates and briefings are also provided to nursing staff/ward sisters etc when incidents are reported and at Safer Medicines Action Group meetings.

5. Please provide details of any suspected breaches of security or break-ins to drug stores during each year specified in this request (2011, 2012, 2013, and to date in 2014). Please include details of the number of incidents, when they took place and whether anything was stolen.

There have been no suspected breaches of security or break-ins to drug stores during the specified years.

If you have any queries about this response please contact the information governance manager at foi@homerton.nhs.uk , in the first instance. If, following that, you still have any concerns, you may contact the Information Commissioner either by letter, FOI/EIR

Complaints resolution, Wycliffe House, Water Lane, Wilmslow, Cheshire SM9 5AF, or by email www.informationcommissioner.gov.uk to take them further.

Yours sincerely

James Cook
Information Governance Administrator

Mike Dunne
Information Governance Manager/Deputy Calidcott Guardian

The information below details drugs that have been reported as missing during the period requested.

As reported at Local Intelligence Network (LIN) meeting – one occasion where CD transfer box was sent from pharmacy to wrong ward – this was due to a ward moving location and taking its name with it. CD box had previous wards name on it. No medications missing. Correct keys with correct ward.	Oct 2011	Rectified immediately – relabelled. No further action required.
5 ampoules of 5mg diamorphine reported as missing on routine stock check (in A&E).	14th Dec 2012	All appropriate action taken at time. The drugs were found in the lip of the CD cupboard 2 days later – new cupboards. A plan to have a cctv directed onto the cupboards is to go ahead.
5 Fentanyl patches reported missing by district nurse who was administering every 72 hours. The log sheet maintained by DN indicated 14 were left on 3rd March 2012 & only 9 remaining on 6th March 2012 indicating that a full box of 5 patches were missing	6th March 2012	Reported via Datix and to Accountable Officer (AO) AO reported to LIN lead AO & CD police. As no substantiated evidence available AO & matron for area raised profile of accounting for all CDs and informed family that CD police had been informed.
On elderly medical ward one 10mg temazepam missing during CD count.	18th July 2012	No other CDs missing. Thought to be lost during counts (pt own tablets in bottle and not blister pack). Ward manager will reiterate importance of

		safe storage and will observe. No other action thought to be required.
Reported that 43 tablets of morphine 100mgs were missing from pharmacy.	12th Nov 2012	Full investigation included: Interviewing staff Statements CD liaison officer asked HUHFT to review processes and review SOPs. Outcome – all meds found (stock box containing 43 tablets had inadvertently been put in TTA bag along with prescribed and dispensed morphine 100mg tablets). All tablets retrieved.
Diazepam 6 tablets missing from cupboard in A&E (TTA pack) – kept in locked cupboard in minor injuries – signed out with 2 checkers.	7th Jan 2013	Diazepam is now kept in CD cupboard in resus area with all other CDs. Investigation has not identified where these meds went. Senior nurse & AO have discussed & are observing. Cctv is installed in resus.
Temazepam that had expired on Delivery Suite (9 tablets of 10mgs) were reported missing.	Aug 2013	Investigation identified that there had been deficiencies in the documentation & checking of CDs on D/Suite. This had been compounded by the fact there were 2 CD cupboards with the expansion of the DS but only 1 CD book. Staff had disposed of the temazepam but not through correct channels.
Reported by a member of pharmacy staff that 34 Sildenafil 50mg tablets were unaccounted for. Pharmacy stock was counted and checked for accuracy. Tablets reported as missing.	21st May 2014	Thorough investigation carried out. All prescription requests for sildenafil cross matched against issues recorded in the pharmacy computer system. 42 tablets were dispensed in accordance with a discharge prescription, a label was generated, however 42 tablets were not issued out of the pharmacy computer system (stock had been received at the end of the day and was not booked into the computer system - hence medication given, but not booked out) - a record of this had been made, but booking out following day had been overlooked. Dispensing technician informed. All stocks of sildenafil to be re-housed in dispensing robot and flagged for frequent stock checks to minimise recurrence. No tablets missing.
MST tablets missing 24 x 30mg tablets 36 x 10mg tablets This occurred when 2 agency nurses & one permanent nurse on duty. HUHFT nurse obtained the CDs from pharmacy	23rd June 2014	Email sent to CD police liaison officer Statements requested & obtained. 24 hour meeting – SI declared. AO is investigating officer. Report due in August. Info to date – no previous concerns for any of the registrants

for TTA. Mitigating circumstances as to why but pt A was discharged with pts B meds. This pt bought them back but there were no CDs. Pt known to trust (regular admissions due to chronic disease). CDs cannot be found. This ward do deal with huge amounts of CDs due to nature of speciality – a new system needs to be sought to ensure safety & security of pt own/TTA CDs.		involved. AO has identified where improvements can be made with systems. New system to be introduced 4th Aug'14. Full report will be submitted on completion.