

On **12 October 2026** the General Pharmaceutical Council's Investigating Committee considered an allegation in relation to **Miss Nneka Catherine Mormah, registration number: 2237158** and determined to issue the registrant concerned with a warning in relation to the conduct alleged.

The Committee concluded that the appropriate outcome in this case is a warning with the wording of:

Miss Nneka Mormah ("the Registrant") was the locum Responsible Pharmacist (RP) and the sole pharmacist working on the 17 January 2025, assisted by a dispenser, when she dispensed the incorrect dose of methotrexate (a high-risk prescription only medicine and an immunosuppressant).

An 88-year-old patient who was under the care of a dermatologist presented a handwritten prescription to the pharmacy for methotrexate to be taken weekly on Mondays as an incremental dose (intended to be increased each week), and folic acid on Fridays.

The prescription was for 14 tablets, but 98 tablets were dispensed instead, namely the weekly dose was erroneously dispensed to be taken daily. Unfortunately, the error was not spotted at the point of calculation, dispensing or the final accuracy check, and the patient was supplied with the medication. Patient A attended the emergency department on 31 January 2025 with raw and ulcerated skin that was bleeding. During his admission, he was treated for extensive skin damage secondary to overdosing on methotrexate. He was in significant discomfort from his skin inflammation and mouth ulcers. On 3 February 2025 arrangements were being made for his admission to the Intensive Care Unit when he was found to have stopped breathing. His wishes were for CPR not to be attempted and, in the absence of resuscitation, he was pronounced

dead. The methotrexate was a factor in his death. The conclusion from the coroner's inquest was that the patient died of natural causes contributed to by an error by the pharmacy as to the dose and quantity of the medication. This resulted in him taking 65mg of methotrexate in an 11-day period, rather than the intended 12.5mg.

The clinical advice received confirms:

- It is important to remind patients of the once-weekly dosing and the risks of potentially fatal overdose if they take more than has been directed
- No Patient Medical Record (PMR) was available for methotrexate, and an incremental (titrating) dose was prescribed. Rigorous monitoring and counselling are required as well as a check that the patient understands the instructions. However, this was not done. The patient did not receive counselling on safe use of methotrexate. Counselling should have included clarifying which day of the week the methotrexate was to be taken, which would have identified it as a weekly dose
- The Proscript system (in-use at the time) alerted the pharmacy team to the fact that methotrexate is usually prescribed weekly and requires regular monitoring and blood tests. Proscript required acknowledgement prior to dispensing the methotrexate which highlights the need to dispense weekly and the high-risk nature of the drug
- Despite it being good practice (as stipulated in the SOP) to check if the patient had an alert card or methotrexate booklet at the point of handing it out, this was not done
- Methotrexate should be used with extreme caution in elderly patients; a dose reduction should be considered due to reduced liver and kidney function as well as lower folate reserves which occur with increased age
- Issuing 98 tablets to an elderly patient who was not stable on treatment is highly unusual and is likely to have presented a risk of harm. This should have prompted the pharmacist to consider the length of treatment, query the quantity prescribed and monitoring with the patient and or prescriber, which was not done

- The clinical check does not simply involve issuing the quantity prescribed. The pharmacist is responsible for considering the length of treatment and whether this would be clinically appropriate given the close monitoring required and potential risks of supplying a large quantity. In the circumstances, no discussion took place with the prescriber and or patient. In this case, namely issuing 98 tablets, the prescriber should have been contacted prior to dispensing
- The checking process was inadequate. This is evident as folic acid was prescribed weekly (on the same prescription). It is recommended that this be on a different day to the methotrexate dose. However, no such check was made

Standards

The pharmacy professional has potentially breached the following GPhC standards:

- Standard 1 – pharmacy professionals must provide person centred care
- Standard 2 – pharmacy professionals must work in partnership with others
- Standard 5 – pharmacy professionals must demonstrate leadership

To mark the seriousness of the issue, Miss Mormah is warned that such conduct must not be repeated and that she must, at all times, adhere to the Standards for Pharmacy Professionals and to meet the statutory obligations of an RP or SI.

Any repetition of this or similar conduct will likely result in further regulatory intervention.

This warning will be published on the register and will be available for 12-months.