NHS
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Clinical Commissioning Group

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16th June 2014

Mr Chinyere Inyama
West London Coroners Court
25 Bagleys Lane
Fulham
London
SW6 2QA

[redacted]

Dear Mr Chinyere Inyama

Following receipt of the regulation 28 report sent to Hillingdon CCG and Central North West London Trust (CNWL) dated 22nd April, arising from the inquest into the death of Tanya Oladejo, please find the Hillingdon CCG response to the concerns outlined the report.

Summary of concerns outlined:

- Responsible clinician making adjustments to the prescribed medication regime, including allowing the GP to vary the amount of sertraline according to the patient's presentation.
- The GP on occasion titrated the amount of amitriptyline prescribed according to the patients presentation
- Responsible clinician not made aware of the unilateral titration of amitriptyline, so unaware a drug prescribed as a sleeping draft was being prescribed and labelled to be taken in the morning.
- Lack of adequate communication between the responsible clinician and GP practice regarding medication.

Timetable of actions taken

The Head of Quality and Safety North West London Commissioning Support Unit contacted CNWL to identify whether the case was reported as a Serious Incident by the Trust. The investigation report from CNWL was requested, which was received by the Head of Quality and Safety on 18th May 2013.

The Initial Management report identified that Tanya was seen in CNWL outpatient clinic and was receiving weekly psychological input. Tanya's last contact with CNWL was on 28 Feb 2013 when she was seen in her psychology appointment. Tanya had failed to attend her 2 subsequent

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Psychology appointments, on 7th and 14th March. The Trainee Psychologist reported the matter after her first DNA with psychology. Tanya was contacted by text message as there was no facility on her phone to leave a voice message. After the second DNA, a letter was sent to Tanya. Tanya also had an outpatient appointment booked on the 2nd May 2013.

The Initial Management Report did not identify hat non-compliance with the DNA policy played a part in Tanya's death, as all relevant paperwork was completed. The Head of Quality and Risk (NWL CSU) confirmed that the Initial Management Report of 22nd March 2013 contained no recommendations for the Trust regarding its DNA policy.

On receiving the Initial Management Report a view was sought from the HCCG mental health commissioner, the clinical leads for NWL Mental Health Programme Board, and Hillingdon CCG medicines management lead on 19th May. It was agreed to explore the time frame and process for notification of any change of medication and follow-up sessions of treatment between GPs and CNWL lead clinician. A response from the HCCG Head of Medicines Management was received on 27th May 2014.

The response confirmed that Tanya was being prescribed the SSRI anti-depressant drug sertraline, by the CNWL Responsible Clinician. The ongoing prescribing of sertraline was provided by the patient's GP who adjusted the dose of sertraline, as authorised by the Responsible Clinician in Outpatients, according to the patient's presentation. Occasionally the GP was prescribing a second anti-depressant drug in addition to the sertraline. This was amitriptyline, a tricyclic antidepressant. This means that sometimes, the patient was taking 2 lots of anti-depressants.

SSRIs and Tricyclic anti-depressants have both been linked with suicidal behaviour. The Responsible Clinician and the GP were both adjusting the dosages of these drugs according to the patient's presentation. Before prescribing or adjusting dosages of any drugs, all clinicians would normally review the full list of medications prescribed for patients.

However, in this case, a full list of medicines does not appear to have been available as the Responsible Clinician did not know the GP was occasionally prescribing a second anti-depressant drug. For some reason, the patient's medication record did not show this.

The process by which the GP and Outpatients departments in CNWL communicate needs to be more robust. As is usual in other areas of communication, patients' full list of medications should follow the patient's journey between different sectors of the health service, so that all prescribers in any setting can make prescribing decisions with the full knowledge of all medicines the patients is currently taking.

To avoid further such incidents, all prescribers should implement guidance from NICE, NPA (National Prescribing Centre) and the NPSA (National Patient Safety Agency) on medicines reconciliation. This is a process which ensures that all medicines taken by patients are documented on admission and at each transfer of care. Every time a patient is transferred from one healthcare

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setting to another it is essential that accurate and reliable information about the patient's medication is transferred at the same time.

This enables healthcare professionals responsible for the care to be able to match-up the patient's previous medication list with their current medication list; thereby enabling timely, informed decisions about the next stage in the patient's medicines management journey.

May 28th 2013 these recommendations were shared with the Medicines Management Teams in Hillingdon, and subsequently in Brent and Harrow CCGs. BHH (Hillingdon, Brent and Harrow) have a shared quality and clinical governance structure). This learning has subsequently been shared with the CCG governing body lead for prescribing, and will be communicated with Hillingdon GPs via the weekly GP newsletter in the week commencing 16th June.

Future Actions Proposed

1. Review the current processes for recording medications in the different sectors by August 2014

2. Review the current processes for communicating this information from one sector to another by August 2014

3. Discuss with the Pharmacy Leads in CNWL and the Hillingdon Hospitals Trust the possibility of developing one standard letter or form for use across all sectors in July 2014

4. Ensure our practice pharmacists review and improve medicines reconciliation processes in practices starting in July 2014 and on-going thereafter.

I hope this addressed the concerns raised satisfactorily but please do contact me again if there are any further queries or actions required.

Yours sincerely

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Hillingdon CCG

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