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1 December 2017

PRIVATE AND CONFIDENTIAL
Mr T W Brennand
HM Assistant Coroner
Coronial Area of Manchester West
Paderborn House, Civic Centre
BOLTON
BL1 1JW

Dear Mr Brennand

Re: Carol Buchanan

Re: Regulation 28 Report to Prevent Future Deaths

I am writing in response to your Regulation 28 Report to Prevent Future Deaths, issued following the Inquest touching the death of Carol Buchanan on 6 October 2017. May I take this opportunity to extend my sincere condolences to the family of Mrs Buchanan for their loss and appreciate this will be a difficult time for the family.

I note that prior to the Inquest hearing, you were provided with a Divisional Review confirming that a number of actions had already been taken by the Trust. Following receipt of the Regulation 28 Report, I requested that the Governance Lead for the Acute Adult Division review the matters detailed in your Report and I am now in a position to respond to your concerns as outlined in Section 5.

Section 5 (1, 2)

I am very sorry to learn that during the course of establishing how Mrs Buchanan came about her death you heard evidence that Mrs Buchanan was prescribed Itraconazole in an out-patient setting without reference to information contained in the GP Summary Care Record (SCR) or verification of medication that Mrs Buchanan was prescribed. The GP SCR is however available to staff in the hospital.

In an out-patient setting, patients or their family/carers are instructed to bring their current medications to the clinic in order to establish what they are prescribed.

The Trust is currently working on the roll out of the Electronic Patient Record (EPR) and Electronic Prescribing. Whilst it is not fully operational yet, when it is complete clinicians working in out-patient clinics will be able to have access to a patient's current prescribed medication.

Work is underway to ensure that all letters inviting patients to an out-patient appointment include a request to bring their current medication to the appointment. An information campaign is planned for publication in GP surgeries to remind patients to do this.

Section 5 (3)

At the time of Mrs Buchanan's appointment on 27 April 2017 I am advised that there was a three week delay in outcome letters to the GP being typed. This was clearly unacceptable and I am assured that this has been addressed and in October 97.3% of correspondence to GP's was completed in the agreed five day standard. This will remain an ongoing action which will be closely monitored via Performance Management reports on a monthly basis.

Section 5 (4, 5 a-d)

The Divisional Review Action Plan detailed a number of steps taken to address the lack of awareness of the rare but serious drug interaction between Itraconazole and Simvastatin. In addition, following the Regulation 28 Report, Doctors and Pharmacists now have access to the British National Formulary (BNF) online. This allows them to reference any drug interaction prior to prescribing.

I was sorry to hear that the family's concerns regarding their mother were not appreciated by the medical and nursing teams responsible for Mrs Buchanan's care. The views of family regarding their relative are clearly important as they will understand when there has been a significant change in their condition. The Trust's Safety Huddle documentation has been revised to include a section where any Family concerns can be highlighted; in addition the Fluid Monitoring Policy has been amended to also take account of a family's views.

In summary of the above, I have attached an Action Plan for your reference which details the improvements that are being implemented in addition to those detailed in the Divisional Review. I hope that my response has provided you and the family with the assurance that the Trust has taken appropriate action.

Please do not hesitate to contact me in the event you require any further assistance.

Yours sincerely

Jackie Bene

Dr Jackie Bene
Chief Executive