Hindley Pharmacy LTD
Hindley Healthcentre,
17,Liverpool road
Hindley WN2 3HQ
Tel-01942-255304

Alan Walsh
HM Area Coroner
HM Coroner's Court
Paderborn House
Howell Croft North,
Bolton BL1 1QY



15TH April 2018

Dear Mr Walsh ,

Further to our meeting of the 13th of April I write to confirm the following points.

From the 1st of April 2018 Addaction took over the management of Wigan's supervised methadone /buprenorphine program .The new system allows each pharmacy providing a supervised methadone/buprenorphine service ,the ability to notify them of each missed supervised dose via the Pharmacyoutcomes website.The Pharmacyoutcomes website has a one ,two and three day missed dose option but we will also continue to manually ring the clients key worker directly when a client has missed 3 days .

All staff and locums have been trained on the system.

All blue supervised prescriptions will state the client's key worker name to assist in efficient reporting .

I hope this clarifies the points we discussed.

Yours sincerely

[redacted]

Alan P Walsh
H M Area Coroner
H M Coroner's Court
Paderborn House
Howell Croft North,
Bolton.BL1QY

9th January 2018

Hindley Pharmacy LTD
Hindley Healthcentre,
17, Liverpool Road,
Hindley. WN2 3HQ
tel. 01942-255304

Dear Mr Walsh,

I write with reference to your letter of the 17th November 2017 regarding the inquest into the death of Paul Geoffrey Mullen. APW/YD2134-2017

I have reviewed our systems for reporting missed supervised methadone ,I am unaware of any "red flag system" ,the only system in place for reporting missed attendance of supervised methadone is the three day rule where the clients key worker is informed of non attendance .I am satisfied this procedure is executed at all times by all my staff and regular locums .

Yours sincerely

[redacted]

Manager /Director

Alan P Walsh
H M Area Coroner
H M Coroner's Court
Paderborn House
Howell Croft North,
Bolton.BL1QY

4TH December 2017

Hindley Pharmacy LTD
Hindley Healthcentre,
17, Liverpool Road,
Hindley. WN2 3HQ
tel. 01942-255304

Dear Mr Alan P Walsh,

I write with reference to your letter of the 17th November 2017 regarding the inquest into the death of Paul Geoffrey Mullen. APW/YD2134-2017

Mr Mullen attended my pharmacy, Hindley Pharmacy, on a daily basis to collect his methadone prescription, his consumption was observed on each occasion by the duty pharmacist. On attending the pharmacy a tick sheet is filled in to record his attendance and the dispensed methadone is recorded in the Methadone Register. The tick sheet allows the pharmacist to see when the client last collected his methadone. If three days are missed we ring the CDT Wigan to speak to the clients key worker or leave a message with the reception if they are unavailable. The Royal Pharmaceutical Society Medicines Ethics and Practice states "If you know a patient has missed three consecutive days of prescribed treatment there is a risk that he or she will have lost tolerance to the drug and the usual dose may cause overdose therefore it is advised to contact the prescriber."
(Please note the days and dates do not tally in your letter for June 2017)
Mr Mullen failed to attend for his methadone on Friday 16th June (he had also missed Monday 12th June) He attended Saturday 17th June were I supervised the consumption of his Saturday dose and gave him a dose to take home for Sunday 18th June. He failed to attend on Monday 19th June and Tuesday 20th June. On Wednesday 21st June I received a phone call from his key worker, she explained that he had failed to attend another appointment with her that day and so we were told to stop the prescription, as is the norm on such occasions we discussed his attendance at the pharmacy and that he had failed to attend for his methadone on 16th/19th/20th June 2017.
Mr Mullen often missed one or two days in a week, when he missed May 17th, 18th, 19th 2017 his prescription was stopped and not restarted until June 3rd.
My staff and I endeavour to help and support these vulnerable people, as much as possible, whilst adhering to the current pharmaceutical practices and procedures.
If I can help you in any way further please contact me.

Yours faithfully

[redacted]

NHS
Greater Manchester
Mental Health
NHS Foundation Trust

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21st December 2017

**PRIVATE & CONFIDENTIAL**
Her Majesty's Coroner
Mr Alan Walsh
HM Area Coroner, Manchester West
Paderborn House, Howell Croft North
Bolton BL1 1QY

Dear Mr Walsh

I write concerning the Regulation 28 following the inquest into Mr Paul Geoffrey Mullen DOB 19/2/1980.

The Senior Management Team in GMMH within the Wigan and Leigh Recovery Partnership (WLRP – which is a partnership between GMMH and Addaction) have undertaken a review into the concerns you have raised. To assist you I have provided the Trust response below each of the highlighted concerns.

**You requested a review of the system referred to at the inquest as the "red flag system" in relation to the reporting of patients who fail to collect prescribed medications, particularly where the patient is due to collect-prescribed medications on a daily basis**

As you are aware representatives from GMMH were not requested to attend Mr Mullen's inquest. Following receipt of your regulation 28 we are aware that the Addaction worker providing evidence at the inquest has used the term 'red flag system'. However, this is not a term that has been used as a system of report by any of our Senior Management team in GMMH or within the WLRP. There is a clinical principle (known colloquially as the 'three day rule') which is outlined in the UK Health Department Drug Misuse and Dependence: UK guidelines on clinical management 2017 Update (often called the 'Orange Book'). It is possible that the Addaction worker providing evidence was referring to this. The Orange Book provides authoritative advice on how clinicians across the UK (including prescribers and community pharmacists) should treat people presenting with problems of drug misuse and dependence. Section 4.6.3.3. specifies that no further dispensing by a pharmacist should occur if three consecutive doses have been missed, and community pharmacists are then advised to contact the prescribing service in this case this would have been GMMH.

**The reporting of a failure to collect prescribed medication direct to a designated and named Key Worker, who may not be within the employment of GMMH, to avoid the report being processed by an intermediary, who does not employ or control the Key Worker.**

We would like to highlight that the primary individuals who require awareness of failures to collect dispenses from the pharmacy are the GMMH prescribing clinicians and the GMMH Pharmacy Liaison Worker. Therefore it is primarily GMMH and not the Addaction keyworker who require awareness of patterns of non-collection because the critical issue is ongoing safe prescribing. The only input of Addaction workers with regard to prescriptions within the WLRP is to put them 'on hold' at the community pharmacy when patients have repeatedly failed to attend appointments with Addaction themselves, usually after four consecutive appointments. They do this for the purpose of promoting engagement with the psychosocial intervention elements they provide which are assistive to recovery.

GMMH does receive information from diligent pharmacists if they have concerns about a patient's presentation or their attendance, for example if someone is collecting only one in three of their dispenses. However, one factor which can effect this reporting being done consistently is the fact that many pharmacies are reliant on locums staff at times. Also, it is the nature of this patient group that they sometimes miss occasional dispenses, at least when they remain in active addiction.

**The review should consider the most expeditious route to report the failure to collect prescribed medications to a Key Worker, who has the responsibility in relation to the patient and who will have direct contact with the patient. The Key Worker will be the most expedient method of contact with the patient.**

It is apparent from your Regulation 28 letter that the information provided by the Addaction worker may not have clearly been explained and the witness may have misunderstood the purpose of pharmacy report. The report by the pharmacy is to inform the prescriber in GMMH – not Addaction - so that the GMMH prescriber can make a clinical decision about the safety of continuing a prescription. In terms of the safety of prescribing, it is not the Addaction worker who has responsibility to the patient but rather it is GMMH, and in professional terms, the Responsible Medical Officer.

In terms of recording and reporting, Addaction and GMMH staff Do share computer reporting systems, albeit on a 'read-only' basis: Addaction staff are able to access GMMH's patient records system, Paris; and GMMH prescribers are able to access Addaction's patient records system, Nebula. The Addaction worker would have had the opportunity to access the GMMH Paris system on a regular basis, and at least prior to every contact/missed contact with Mr Mullen. Following a review of our systems there is no evidence to show that GMMH had been informed by the pharmacy that Mr Mullen had missed dispenses, GMMH could not have informed the Addaction worker therefore. If we had been informed this would have been recorded in the PARIS notes and have been accessible by the Addaction worker.

**The timescale in relation to a report being submitted to the Key Worker, taking account of the fact that the present three day timescale may not be appropriate for patients who are known to be very compliant and who collect prescriptions on a regular daily basis. In those circumstances the concern and the need to check the concern may arise after either one or two failures to collect the prescribed medication.**

It would be unrealistic for community pharmacy to advise GMMH each and every time a patient missed one dispense. The clinical advice inherent within the Orange Book advises that three days or more is the critical period in which tolerance to opioids may begin to be lost, and it is this lack of tolerance, which is the critical issue in terms of safety. In that sense, all parties' best promote safety by consistently following the 'three day rule'.

**The training of pharmacy, mental health practitioners and any other healthcare professionals in relation to the reporting of failures to collect prescribed medication taking account of the circumstances relating to the case of the deceased, where the failure to collect the prescribed medication was not reported, as soon as practicable, after the third consecutive failure to collect the medication.**
For reasons of the safety of prescribing, which is the point of the 'three day rule'. It has always been the agreed expectation that all communications, whether from pharmacists or Addaction workers, are routed through the GMMH Pharmacy Liaison Worker, and the reviewing team's opinion is that this agreement should continue.

GMMH is not able to determine, require, nor insist upon training of staff in other agencies other than their own. The training needs of community pharmacists will be determined primarily by the Local Pharmaceutical Committee (LPC) and the Clinical Commissioning Group (CCG); those of Addaction staff by Addaction; and mental health staff by North West Boroughs NHS Foundation Trust. GMMH continues to support any training initiatives to pharmacists where this is requested by the Local Pharmaceutical Committee and/or the CCG which we have done in the past.

The only input of Addaction workers with regard to prescriptions within the WLRP is to put them 'on hold' at the community pharmacy when patients have repeatedly failed to attend appointments with Addaction themselves, usually after four consecutive appointments. They do this for the purpose of promoting engagement with the psychosocial intervention elements they provide which are assistive to recovery.

Following a review of the concerns you have raised it appears that there may be a lack of awareness of the importance of the 'three day rule' within the body of community pharmacists. In response to this the GMMH Operational Manager has arranged to have discussions with the Clinical Commissioning Group and Local Pharmaceutical Committee to draw their attention to the concerns you have raised and raise awareness of the 'three day rule'. In addition, the Pharmacy Liaison Worker will proactively contact all community pharmacies by the end of January 2018 to similarly raise awareness of the 'three day rule' and personally introduce himself and his role in order to further develop partnership working.

It is of regret that the GMMH prescribing Doctor, who submitted a statement to the Inquest, was not invited to give evidence at Mr Mullen's inquest, which may have assisted in providing a clear account of the procedures in place within the Wigan and Leigh Recovery Partnership between Addaction and GMMH. GMMH clinicians always value being called by our Coroners to provide evidence if this can in any way assist the Coroner in reaching his or her conclusions particularly if any of the Trust services have been involved in an individual's care.

We hope that this response provides assurance to Mr Mullen's family and yourself that the Trust has taken the concerns raised during Mr Mullen's inquest seriously.

We would like to make our Bolton Coroners aware that GMMH will only remain to be the clinical providers in the WLRP until 31/3/18 after which the contract will cease, and Addaction will become the sole provider. We would like to assure you however that GMMH has completed a full review of its systems and will put in place any necessary measures to ensure a safe and smooth transition for the service user population.

Yours sincerely

Beverley Humphrey
Chief Executive