HOPWOOD HOUSE MEDICAL PRACTICE

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Practice Ref: P85014

25-Jun-2019

FAO Ms J. Kearsley
Her Majesty's Senior Coroner
The Phoenix Centre
L/CPL Stephen Shaw MC Way
Heywood
OL10 1LR

Dear Ms Kearsley,

Re: Report to prevent future deaths following the inquest of SHAW, Beverley (Miss) [redacted]

Further to your Regulation 28: Report letter to prevent future deaths (1) and the inquest for Miss Beverley Shaw, Hopwood House Medical Practice have reflected on the learnings from the inquest and looked further into the electronic records of the deceased patient.

I will answer the concerns in the order addressed by the court.

1. **Communication**

Since the inquest we have as a practice reflected on Beverley's death and have discussed what we could have done differently to prevent her death. We noticed that in her records she had many failed appointments (DNAs) and possibly not fully engaged with clinicians about her health. In April 2019 we put together a DNA policy. The policy outlines that patients who DNA shall be discussed in the practice meeting and a suitable method of contacting the patient should be sought. On reflection with this patient if we had done this, Miss Shaw could have been referred onto the Focus Care worker linked to our practice and she would have had a home visit assessment. From this we may have been made aware of the extent of her Butane abuse and this could have been communicated to the clinicians and Turning Point.

From the practice team meeting and reviewing her medical records, not much was known about her butane abuse. As you have highlighted, only one document from the 15th May 20/18 simply recorded "Use of cans of butane daily". There was no further information given on this. This was written under the section of illicit drugs and I feel that on reading this document that it is possible that this statement could have been missed by the GPs when coding. It may be also to have been overlooked by the practice as the letter was from a commissioned addiction service, that the Butane addiction was dealt with. However on our behalf perhaps, we could have prompted for more information regarding this.

On speaking to a drugs worker (that works for Turning Point), attached to our practice, regarding the recreational use of Butane. He was surprised to hear of the volume that she was using. He was not aware of assessing any patient who had used Butane to the extent that Miss Shaw had and he would feed back our concerns to his colleagues.

We also found the electronic code "Misuse of Butane EMISNQMI97". That we will use in future to code this on the Problem List.

Regarding our communication with Turning Point, we responded to their letter on the 15th May 2018 by emailing the information requested. They asked for recent blood tests results, and a copy of her summary. This included her past medical history and current medication. A task was sent to reception promptly by the GP, on reading the letter to send the requested documentation. The audit evidence for this is as attached.

Medication Review

The last medication review was done by one of our regular locum doctors who has been working at the practice for the last 3 years. From the practice meeting we concluded that the medication review was sub-adequate and the lead GP of the practice will feed this back to him. However, given the time limits and pressures in primary care, and the inconsistencies of CCG employed pharmacists, the practice has made a decision to employ a clinical pharmacist do complicated medication reviews and help with the workload.
Despite this, as highlighted already by the letter from the 15th May 2018 sent by [redacted] (Consultant Psychiatrist), they have a clear accurate record of Miss Shaw's medication and any drug interactions that may have been overlooked by the practice, perhaps should have been double checked then.

Looking at the electronic records, and using the Safety check tool, there are, "no high severity warnings" or contra-indications with the medications. There is a "medium severity warning", regarding use of Methadone and Acute Hepatic failure, suggesting avoid or a reduced dose is used. Again, there was a "medium severity warning" regarding the concurrent use of Methadone with Olanzapine 5mg Tablets, Amitriptyline, Promazine and Pregabalin causing a prolonged QT interval. The manufacturers advice was to avoid use with 2 or more drugs associated with QT prolongation. Had methadone been added to the medication list, this perhaps would have been avoided.

This patient was under Pennine MSK persistent pain service Tier 3. Miss Shaw was suffering from Psychological distress in the context of Trigeminal neuralgia and had a history of Ekbom's syndrome.
In the last clinic letter from the pain service dated the 3rd August 2018, they had advised to reduce the Olanzapine to 12.5mg per day in 2 divided doses, then after a month to reduce to 5mg twice daily .which we was promptly changed as per advice.

Duloxetine, Pregabalin, Amitriptyline and Olanzapine were started due to her chronic facial pain.

Promethazine was started by Raid on the 11th September 2017. She had a follow up appointment with mental health that she did not attend. As Miss Shaw's engagement with the community mental health team was compromised this may have had an effect on continuing the Promethazine. However, I do agree this should have been picked up during medication reviews and encouragement given to attend her appointments with the community mental health team. Perhaps a reducing regime agreed with the patient would have been another suggestion.

Miss Shaw's medication was listed in the letter from MSK pain clinic. However I note that Methadone was omitted from the list. I am not sure whether Miss Shaw disclosed her Methadone intake and perhaps some of the chronic pain medication such as Amitriptyline, Duloxetine, Pregabalin and Promazine could have been avoided if the pain clinic were aware of her methadone or Butane use.

I note a mental state exam was done at this clinic and there was no evidence of depressive cognition.

I note that there were several opportunities where she could have had some of her chronic pain medication reduced. However these were missed.
Again this will be avoided in future when a clinical pharmacist is employed by the practice and can go through complicated medication reviews. The GPs in the practice are aware of this as a significant event and will be mindful of patients on sedatives, chronic pain medication with methadone and substance abuse.

Records
This is related to the commissioned provider and I hope that they can resolve this issue with the transfer of full records with a new provider.

We, at Hopwood House Medical Practice are deeply saddened that Miss Shaw's death could have been as a result of poor communication and that steps could have been taken early to prevent this death. Unfortunately we have had to learn humbly from this and will in the future be much more vigilant with communication and correspondence, and also medication reviews. Changes have already been made, to prevent any further similar deaths and will be ongoing in the future.

Going forward I hope that communications with our drug and alcohol, and other services improve to ensure that we are made aware of the dangers of Butane. I have also suggested to

the practice that we add Methadone to the patients medication list in all cases to highlight to clinicians that they are receiving this from the drugs and alcohol team.

The practice would also, if supported through Oldham CCG have a meeting with Turning Point separately as a learning event to see what further changes we can both make to make sure miscommunications are avoided in the future

Please express our deep condolences to the family.

Yours sincerely

[redacted]
GP Priniciple
Hopwood House Medial Practice

[redacted]