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Clinical Commissioning Group

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Our ref: 2303

Emma Whitting
HM Senior Coroner
Bedfordshire and Luton
HM Coroners Office
Woburn Street
The Court House
Ampthill
Bedfordshire
MK45 2HX

Dear Ms Whitting

Inquest into the death of Graham Saffery

Thank you for your letter dated 17 September 2019, detailing your concerns following completion of the Inquest into the death of Graham Saffery.

Firstly, on behalf of Bedfordshire Clinical Commissioning Group (CCG), I would like to pass on my condolences to Graham Saffery's family for their tragic loss, such a difficult time for family and friends.

Please accept my apologies for the delay in responding. Our Head of Medicines Optimisation, Primary Care team and Quality and Safety team have been involved in the investigation and I understand in depth discussions have taken place with Queen Parks surgery and [redacted] Further questions arose from the investigations which required additional information to be obtained causing delay. Our investigation has now concluded and I am in a position to formally respond.

We would like to address the following two points raised in your letter:

1. *Although at the Inquest I heard from [redacted] from Queens Park Health Centre, I did not hear from [redacted] who had last attended on Graham on 14th June 2018 and as a result I made no particular finding about Graham's presentation on that occasion; however, I was concerned that, at least from a reading of the patient records, [redacted] did not appear to have observed that, since 23 May 2018, Graham had been receiving double his prescribed dose of Amitriptyline, apparently without explanation.*

CCG response: [redacted] has submitted a detailed report to the CCG for consideration alongside the practice report. During the consultation (14th June) [redacted] noted the dose of the amitriptyline to be 75mg daily. The dose of amitriptyline had been recommended to be doubled by [redacted] at East London NHS Foundation Trust (ELFT), our community mental health provider, which we have confirmed verbally with ELFT, but no communication

had been received by Queens Park to this effect. The practice have never prescribed amitriptyline 150mg daily, however it is possible Mr Saffery may have been taking this dose on the recommendation of the Mental health specialist, following the telephone consultation. This is the maximum licensed dose for amitriptyline for depression as per the specific product characteristics and therefore is within guidelines.

2. was also concerned to learn, through evidence provided by Bedford Hospital prior to delivering my Summing Up and Conclusion, that although the hospital discharge letter (in respect of Graham's admission 27-29 May 2018) had been downloaded by the Queens Park Health Centre at 15:14 hrs on 31 May 2018, [redacted] informed the inquest that he had not been made aware of it and that the letter had not been incorporated into Graham's patient records.

CCG response: The hospital discharge summary had been received by the practice through the electronic GP portal information system and rather than going into the 'letters' inbox at the practice it had gone into the 'reports' inbox and therefore had not yet been actioned as letters are processed with a higher priority. This was an administrative error which has now been addressed with the hospital.

Members of the Primary Care team and Medicines Optimisation team have met with Queens Park surgery and the practice have reflected on the tragic death of Mr Saffery and made changes to their prescribing protocols and management of controlled drugs, in particular how they manage patients on weekly prescriptions.

The Head of Medicines Optimisation at the CCG has shared the detailed report from Queen's Park Surgery with [redacted] Controlled Drugs Accountable Officer for the East of England (NHS England) to ensure that the learning is shared across the region.

As learning from this incident, Bedfordshire CCG has taken the following actions to help identify any future patients at risk:

- The case has been discussed at the Prescribing Committee and it was agreed that the learning should be shared across all practices.
- The CCGs Locality team have developed and published a SystmOne search to identify any patient, in the GP practices, on a high strength opioid and a tricyclic antidepressant.
- All prescribing leads have been briefed on this case at the prescribing leads meetings and asked to run the search and ensure all patients are reviewed and the review is clearly documented in the notes, with the necessary care plan as appropriate.
- The NHS National Business Services Authority have published a dashboard to include patient numbers on a combination of oxycodone and amitriptyline and the CCG team will continue to monitor numbers to ensure reviews have taken place.
- The Head of Medicines Optimisation has met with the chief pharmacists at both the Luton and Dunstable Hospital and Bedford Hospital and also the Chief pharmacist at ELFT to discuss the learning from the case.

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We are not expecting that all patients identified on a combination of an opioid and tricyclic antidepressant will have their medication stopped, but the risk associated with the level of sedation will be reviewed and action can then be taken as appropriate. The use of low dose opioids with low dose amitriptyline may be clinically appropriate.

I hope that I have been able to answer your questions. If I can be of further help, please get in touch.

Yours sincerely

Accountable Officer