Professor Stephen Powis
National Medical Director
Skipton House
80 London Road
SE1 6LH

Ms Louise Hunt
Senior Coroner
Her Majesty's Coroner for the City of Birmingham and the Borough of Solihull, Coroner's Court, 50 Newton Street, Birmingham, B4 6NE

13th November 2018

Dear Ms Hunt

Re: Regulation 28 Report to Prevent Future Deaths – Sufia Begum

Thank you for your Regulation 28 Report ("Report") dated 19/09/2018 concerning the death of Sufia Begum on 24/04/2018. Firstly, I would like to express my deep condolences to Ms Begum's family.

Your Report concludes Sufia Begum's death was a result of an unrecognised drug reaction.

Following the inquest you raised concerns in your Report to NHS England and the Clinical Commissioning Group ("CCG") regarding unrecognised drug reactions and that not all doctors may be aware of the British National Formulary ("BNF") mobile device application ("APP") in identifying potential drug interactions. You stated that an alert about this APP should be sent to all NHS Trusts and General practitioners ("GPs") to assist in preventing future deaths from unknown drug interactions.

The present position is that all hospital doctors have access to the BNF tool via an electronic prescribing system which will alert prescribers to potential serious drug interactions. All GPs and hospital doctors therefore have access to the online BNF and/or app, however not all may be aware of it.

In addition, GPs also have access to alert systems which alerts prescribers to potential reactions when prescribing any drug to a patient. In hospitals, such electronic prescribing is not yet universally available. Some clinicians continue to utilise the hardcopy paper version of the BNF.

Both GPs and hospital consultants do have access to pharmacy expertise to support prescribing concerns.

Therefore, there are mechanisms to protect patients but these did not function sufficiently to protect Ms Begum.

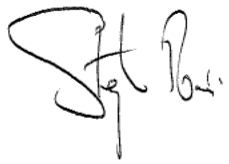
The following actions will therefore be taken to reduce the risk of reoccurrence and to protect other patients going forwards.

1. Sandwell and West Birmingham CCG have confirmed that awareness will be raised to all local GPs by December 31st 2018, about the existence of the APP for use when checking drug interactions via the CCG Protected Learning Time ("PLT") events, CCG Clinical Chair's communications, and existing clinical leadership groups that includes membership across the CCG footprint.
2. NHS England will ensure the details of this case are anonymised and distributed across all GPs in the West Midlands via its regular appraisal newsletter.
3. NHS England has already distributed learning across all CCGs and Providers in the West Midlands via shared learning at the West Midlands Mortality group meeting held on 16th October 2018.
4. Sandwell and West Birmingham Hospitals NHS Trust confirm the following actions have either occurred or are due to occur:
    1) The case was reviewed in pharmacy in September 2018 and lessons learnt from this was shared
    2) Trust wide communication in October 2018 has occurred about the use of the BNF mobile app for checking drug interactions. This went to all staff who prescribe or administer medication
    3) Trust wide email to all trainees from the Clinical Tutor in October 2018 about the incident, lessons learnt, encouraging use of mobile BNF app for checking interactions, the situations to be particularly careful in and the importance of co-working with pharmacists
    4) Trust wide email to all Consultants and middle grade staff in October 2018 to emphasise drug interaction safety checks and encourage use of the BNF app.
    5) Other actions from the SI report due over the next 4 months:
        a. Medical Director to audit the use of the app amongst trainees in December 2018 to confirm its continued use and confirm that communication has got to non-medical prescribers as well.
        b. Trust Alert to all staff via the "Microguide" system (an electronic portal which hosts guidance) regarding potential interactions (November 2018)
        c. Introduction of electronic prescribing and ensuring that "incompatibility alerts" are not disabled on Unity (Patient Information System, February 2019)
        d. Review of antibiotic prescribing for patients with cardiovascular disease by the clinical lead for microbiology (February 2019)
        e. Remind all prescribers to follow prescribing guidelines fully (Director of Governance 30 September)

Overall I am satisfied the CCG, Trust and NHS England have taken the issue seriously in order to help to prevent a reoccurrence.

Thank you for bringing this important patient safety issue to my attention and please do not hesitate to contact me should you need any further information.

Yours sincerely,



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