Greater Manchester Health and Social Care Partnership
4th Floor
3 Piccadilly Place
London Road
Manchester M1 3BN

T: 07825 675 823
E: [redacted]

Your Ref: Case 313457

04 June 2020

Ms A Mutch OBE
HM Senior Coroner
Coroner's Court
1 Mount Tabor Street
Stockport
SK1 3AG

By email: coroners.office@stockport.gov.uk

Dear Ms Mutch

Re: Regulation 28 Report to Prevent Future Deaths – Wendy Margaret Wilkes 06/08/19

Thank you for your Regulation 28 Report dated 21 April 2020 concerning the death of Wendy Margaret Wilkes on 06 August 2019. I am sending this reply by email to the above address as discussed and agreed by my PA [redacted] and your office today.

Firstly, I would like to express my deep condolences to Wendy Margaret Wilkes' family.

The inquest concluded that Wendy Margaret Wilkes' death was a result of 1a) ethanol toxicity on a background of concomitant use of gabapentin, zopiclone, diazepman and amitryptiline; II) Alcohol related fatty liver disease.

Following the inquest you raised concerns in your Regulation 28 Report to NHS England regarding that there was no clear system of alert notes/follow up review appointments at her GP practice despite the extent of the prescribed medication; The GP practice did not appear to have a system to ensure that prescribers were aware that her alcohol use was high and to assess the risk of mixing alcohol with the prescribed medication.

I have noted that your Regulation 28 letter has also been sent to the Clinical Commissioning Group concerned and I will leave it to the named respondent to address the concerns which you have expressed. My letter therefore addresses the issues that fall within the remit of GMHSCP.

Summary of actions taken or being taken by the organisation involved.

The CCG will ensure that;

1. Practices will undertake a search on a quarterly basis for patients coded as taking opioids or neuropathic drugs cross referenced with alcohol dependency so that they can understand their existing cohort of at risk patients, place a flag on their record, review their medication and contact them to discuss their medication and their consumption of alcohol.

2. When a practice becomes aware of any patient who has overdosed, whether accidentally or intentionally, a flag should be placed on their records, their medication will be reviewed and a discussion be had with the patient about their medication and their alcohol consumption. Place the patient on weekly prescriptions to reduce the possibility of any further harm if it is deemed clinically appropriate after a discussion with the patient.

Actions taken or being taken to prevent reoccurrence across Greater Manchester.

1. Learning to be presented/shared with the Greater Manchester Quality Board. This meeting is attended by commissioners, including commissioners of specialist services, regulators, Healthwatch and NICE.

2. Learning to be shared with the Greater Manchester commissioners of services to assure themselves of the quality of services they commission.

3. An alert will be issued to all GP practices to ensure that they have clear systems of alert notes/follow up review appointments for individuals with extensive prescribed medications. The alert also requests GP practices consider how their systems can alert prescribers to patients with high alcohol usage when prescribing medications to ensure effective risk assessments can be carried out.

Previously, across Greater Manchester, a set of nine standards were developed to improve quality and reduce unwarranted variation in the delivery of primary care. The standards were first developed in 2014 and a refreshed version implemented in 2018.

The system remains committed to ensuring that Standard 7 – embedding a culture of safety – which aims to make Greater Manchester the safest, most effective place to receive medicines and treatments is achieved. It aims to improve reporting rates of medicine related safety incidents, improve uptake of safety audit software and reduce medicine safety incidents over time. Specifically, this includes establishing

processes of shared learning / peer reviews within a practice and neighbourhood setting, including incident reporting, lessons learnt, embedding remedial actions and review processes. All 10 localities implemented this standard in full or in part and are committed to improving medication safety. Local examples of this include locally commissioned quality improvement programmes, closer working with CCG medicines management teams, inclusion of safety champions and medicines management peer reviews.

The Greater Manchester Health and Social Care Partnership (GMHSCP) is committed to improving outcomes for the population of Greater Manchester. In conclusion key learning points and recommendations will be monitored to ensure they are embedded within practice.

I hope this response provides the relevant assurances you require. Thank you for bringing these important patient safety issues to my attention and please do not hesitate to contact me should you need any further information.

Yours sincerely

Dr Richard Preece
Executive Lead for Quality and Medical Director