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[redacted]

2 November 2021

Private & Confidential
Ms Alison Mutch
H M Senior Coroner
Coroner's Court
1 Mount Tabor Street
Stockport
SK1 3AG

Dear Ms Mutch

Regulation 28 Report - Ms Elaine Michelle Inns (deceased)

I refer to your letter dated 26 August 2021 in relation to the above and thank you for contacting NHS Stockport Clinical Commissioning Group (CCG) in this matter. I am sorry to learn of the circumstances of Ms Inns's death and offer my sincere condolences to her family.

I note the cause of death as detailed in the report and your concern that future deaths will occur unless action is taken. The areas of concern relate to the prescribing of an opiate medication to a patient who was known to dose erratically and to use alcohol in significant quantity. I have been assisted in my investigation by the GP Practice involved who I was pleased to note had undertaken a detailed significant event analysis prior to the CCG receiving your Regulation 28 report.

I will now address the specific points raised within your report:-

- **You express concern that Ms Inns continued to be prescribed a combination of medications including a number of powerful pain killers although it was well understood that she was using alcohol in significant quantity whilst using prescribed medications**

From a review of the clinical records in this case it is clear that Ms Inns' history of alcohol excess is included in her history and that attempts to support her in relation to this issue had been made previously including a referral to the Drug & Alcohol Service in 2019. However, a review of more recent consultation notes highlighted that Ms Inns' current level of alcohol consumption was not directly explored when undertaking a medication review or during consultations relating to her general health and wellbeing.

Learning & Actions

The practice discussed the risk associated with opiate prescribing and the significant polypharmacy in this case which was the result of historical additions to Ms Inns' medication regime, which of which pre-dated current NICE guidance on prescribing for chronic pain. The practice acknowledge that it is important to review and challenge these regimes.

As part of the review of this case the practice re-visited a previous MHRA alert regarding the co-prescribing of Oxycodone and Amitriptyline and with this in mind the practice carried out a search of all patients with this combination and has now invited them for review with the practice pharmacist.

The investigation identified the need for all clinicians to enquiry specifically about alcohol when reviewing patients on opiates and TCAs/ Gabapentinoids as a matter of routine and in order to support this process the medication review template has been reviewed to include:-

- Discussion about alcohol whilst taking opiates (tick box)
- GP informed (tick box)
- Confirmation of whether patient is takin any other medication which may lead to increased opiate levels / sedation (yes/no)

All registered patients identified as drinking whilst prescribed opiates are now routinely flagged for GP review as a matter of urgency.

- **You express concern that Ms Inns used prescription medications without following the prescribing dose instructions**

The practice acknowledge that despite dosage instructions being clearly included with any prescribed medications, Ms Inns was not following the recommended dose instructions and there is a need to be explicit and clear when entering instructions, dosage, quantity and intended frequency of prescription of controlled medications. This needs to be clear to the patient so that they can safely self-administer and also to the prescriber so that they can easily identify possible misuse or early requests.

Learnings and Actions

All early prescription requests will be rejected and the patient informed; the patient will need to consult directly with a GP in relation to the prescription request and circumstances which have led to early request.

Medication reviews for this group of patients will be six monthly and will be undertaken by either a GP or a pharmacist. The review will be brought forward if there are any concerns in relation to potential misuse of controlled medications, or where there is reference to mood disturbance, excess alcohol use or other drugs of concern.

A medication review will include:-

- Establish indication and whether other treatment indicated for underlying pain
- Clear dosage and directions on prescription
- Consider weekly prescriptions if indicated
- Task sent to all clinicians to raise awareness if concern
- Alert on notes in EMIS clinical system to warn prescribers to check dates if concern
- GP to discuss involvement of other teams: psychological medicine in primary care, drug and alcohol team, pain clinic as appropriate
- Consider drug holiday or supportive dose reduction
- If continuing medication patient to sign opioid management plan and treatment agreement (as per GMMMG)

In addition, a specific audit is to be undertaken to identify all patients currently prescribed oral morphine (acute or repeats). Notes will e reviewed to ensure identification of the following in each case:-

- Clear indication in the notes
- Dose of oral morphine is clear, and the directions for use include the volume and how long this should last (eg 2.5 to 5 mls every 4 hours for breakthrough pain, 200 mls fortnightly)
- Consideration of whether the patient should be on slow release/ slow release dose of medication reviewed if high oral morphine use
- Check notes for signs of mood disturbance/excess alcohol use/other drugs of concern
- Flag any concern / overdue medication review (review y pharmacy team with GP input as required)

Management of Communication

This investigation also highlighted that Ms Inns had consulted with Mastercall Out of Hours Service on 20/12/2020; she was reported to have been intoxicated and asking for support from her GP in relation to alcohol dependency. Whilst Mastercall did advise the patient to contact the practice and did write to the practice. However as there was no highlighted action within the letter, the correspondence was filed without having been referred to the GPs.

Learnings and Actions

As a result of this case, the administrative process at the practice has been changed; in all cases where a patient has a safeguarding alert on their records, all out of hours correspondence is now referred to the GPs for review / action which means that any such communication would be reviewed within 48 hours.

Conclusion

Having reviewed this overall investigation and the circumstances which led to the issue of your Regulation 28 report, I reach the conclusion that the key issue is the prescribing of opiates and I am satisfied that appropriate steps have been taken to ensure the safe prescribing of opiate medication at the individual practice and across the wider Stockport GP community. I will ensure that the most up to date opiate prescribing guidance is shared across our practices and work with colleagues across our system to ensure adherence to best practice guidance.

Thank you again for contacting NHS Stockport CCG in this matter; I hope the above provides relevant assurance. However, if you do require any further information then please contact me.

Yours sincerely

Dr [redacted]
Medical Director