Greater Manchester
Mental Health
NHS Foundation Trust

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Trust Management Offices
First Floor, The Curve
Bury New Road
Prestwich
Manchester
M25 3BL

[redacted]
Web: www.gmmh.nhs.uk
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Dr Nicholas Shaw
HM Assistant Coroner for Cumbria Area
Fairfield
Station Road
Cockermouth
Cumbria
CA13 9PT

20 January 2022

Dear Dr Shaw

Re: Darrell Devlin (deceased) Regulation 28 Preventing Future Deaths Response

Thank you for highlighting your concerns during Mr Devlin's Inquest which concluded on 18 November 2021.

On behalf of the Trust can I apologise that you have had to bring these matters of concern to the Trust's attention. We would like to extend our sincere condolences to Mr Devlin's family and friends at this very sad time.
I hope the response below demonstrates to you and Mr Devlin's family that GMMH have taken the concerns you have raised seriously and will learn from this.

Please see the Trust's response in relation to the concerns you have raised, and the actions taken by the Trust:

1. **Darrell first came into contact with Unity (the drug and alcohol service that your trust was contracted to provide for Cumbria) in 2015. and his final episode of care began on 30th January 2020 when he self referred to ask for treatment for daily heroin use. At the time of his death he was receiving a daily dose of [redacted] Methadone supplied every week. Evidence heard at the inquest covered the final 7 months of this treatment episode, during this period I heard of 6 telephone contacts, the last just 18 days before Darrell died, however he was never seen in person and never tested for drug use.**

   As highlighted at the inquest, Mr Devlin passed away during the Covid-19 pandemic when health and social care services continued to be affected by associated restrictions. Cumbria's Community Addiction Services were known as Unity and delivered by GMMH until 30th September 2021.

   Unity remained open throughout the pandemic period and continued to operate to protect those most vulnerable and reduce the burden on other healthcare services.

However, face to face contact was advised to be kept to a minimum by Public Health England and the Department of Health - (see guidance applicable at the time)

([Withdrawn] COVID-19: guidance for commissioners and providers of services for people who use drugs or alcohol - GOV.UK (www.gov.uk).

In line with this, the multi-disciplinary Senior Leadership Team (SLT) for the GMMH Addictions Division, reviewed service delivery and made adaptations to support changes where required and GMMH developed Trust guidance for staff that supported the Multi-Disciplinary Team to review each service user in terms of their risk factors, stability on their prescribed medication and their engagement with services.

GMMH Community Addiction Services recognise that face to face contact is the preferred method of communication and, from mid-2021, services began planning for the re-introduction of these in response to the easing of Covid-19 restrictions.

For high-risk service users face to face reviews were always maintained, however, for the remaining service users, action plans were put in place to re-introduce face-to-face appointments for all other service users. The service issued guidance to all staff-advising all first appointments should to be face to face and specific guidance in ensuring everybody had been drug tested within a 12-month period. Service User contact information is closely monitored by the Senior Leadership Team monthly and by local managers on a weekly basis.

2. **Apart from admitting to a single bag of heroin on 1 occasion Darrell consistently told his drug workers that he was abstinent from illicit drugs or alcohol and was well maintained on his daily dose of methadone. The forensic toxicology report (of which I attach a copy for your information) however indicates he was almost certainly not truthful. I am concerned that reliance on remote contacts and lack of testing make it very difficult for drug workers to accurately assess and suppor1 their clients, and put the clients at risk of harm or death due to excessive dosage or polydrug exposure on top of their regular medication, as in this case. I am aware that face to face appointments were avoided where possible due to the Covid pandemic but feel this case highlights a need for more effective supervision than that given to Darrell.**

Mr Devlin had been reviewed considering national and local guidance with his risk management plan updated to reflect this on 21st April 2020. His prescription was changed from a daily supervised dispense of methadone to a weekly collection. This clinical decision was made due to Mr Devlin remaining mostly illicit drug free and positively engaging with Unity services. The decision reduced the risks of contracting Covid-19 and supported government requirement to limit social contacts, deemed as paramount due to the respiratory health problems experienced by Mr Devlin.

There were continual checks to ascertain Mr Devlin had access to naloxone (a life-saving opiate antagonist emergency medication) and a discussion is recorded where Mr Devlin was encouraged to be honest with staff surrounding any illicit drug use.

Unity services allocated service users to pathways, based on risk, and presenting need. Mr Devlin was allocated to the pathway known as "Recovery Journey" which provided contact every 4-6 weeks and, during the Covid-19 restriction this was via a telephone review. In the year prior to his death, Mr Devlin is described in each telephone contact as stable on his prescription and reporting no illicit use (except for 21st October 2020 where he reported he shared one bag of heroin with his partner). There were no telephone contacts during which Mr Devlin sounded drowsy, intoxicated, incoherent or exhibited any behaviour indicative of illicit drug use.

If Mr Devlin had exhibited any signs of illicit drug use during his telephone appointments, his Recovery Coordinator would have invited him in for a face-to-face appointment and undertaken a clinical assessment and review, to consider past and current substance use and the need for a standard oral drug screen. Mr Devlin did not exhibit any signs of illicit use during his telephone contacts; therefore, he was not seen in person up to the time of his death. This practice was in line with the national and local guidance in place at that time.

GMMH work in partnership with local community pharmacies via sub-contracting arrangements, meaning they have a responsibility to assess service users' presentations when collecting their prescriptions and to alert GMMH Community Addiction Services when someone appears intoxicated and there were no concerns raised nor calls made to Unity regarding Mr Devlin's weekly presentation. However, his partner frequently collected his medication for him due to his respiratory problems and the risks associated with Covid-19. We acknowledge that given his partner was collecting his medication, to minimise other risks, one of our usual safeguards was not in place.

GMMH Addictions Division have a comprehensive risk assessment training package, which requires mandatory completion by all clinical staff. Considering Covid-19 and implications to care and treatment, this training material will be revised and updated, to include a case study reflecting some of the issues raised in Mr Devlin's death. This will be completed by end February 2022.

3. **Despite the presence of bronchopneumonia, a natural illness, it is my view that the drug combination -particularly the use of Flubromazolam -was the major factor in Darrell's death.**

Unity used two oral drug screening tests. The main standard oral screen allowed staff to select one or more of a range of substances such as opiates, 6-monoacetylmorphine (6-MAM), methadone, buprenorphine, and benzodiazepines (although the particular type of benzodiazepine was not specified in the result of this test). For those prescribed OST, ordinarily the only test requested would be for opiates, 6-MAM and, if the patient was not on supervised consumption, the prescribed medication (methadone or buprenorphine). Prior to the Covid-19 pandemic, Unity would have completed the standard oral screen

every three months for those prescribed OST and on the pathway applicable to Mr Devlin.

Due to the restrictions related to Covid-19, Unity had not been completing routine drug screens on the usual basis. Instead, the use of the drug screens was determined by clinical risk and need.

Mr Devlin was prescribed clonazepam by his GP to treat his epilepsy, meaning any drug test for benzodiazepines would be expected to show as positive. Furthermore, Unity had no suspicion that Mr Devlin was using illicit benzodiazepines and, as flubromazolam is a novel benzodiazepine, none of the drug testing technologies afforded to Unity used would have been able to detect it. The Verum screen which became available after the onset of the Covid-19 pandemic (July 2020) and can detect up to 50 substances, could allow the identification of a wider range of benzodiazepines but based on Mr Devlin's history, Unity would not have considered this was clinically indicated throughout his treatment.

We note the high blood concentration of flubromazolam in his toxicology report but given his long-term prescription of clonazepam it would be likely that Mr Devlin would have a high degree of tolerance to benzodiazepines. We feel it would be likely that the contribution of the prescribed sedating drugs (such as pregabalin, dihydrocodeine and clonazepam) might have contributed to his death as well as the flubromazolam, methadone and the bronchopneumonia.

4. **I note that since Darrell's death the contract to provide drug and alcohol services in Cumbria has transferred to Humankind, and thus I am addressing the report to them as well while acknowledging that they played no part in Darrell's care.**

In review of the concerns raised in your report, GMMH met with Humankind, the new service provider in the county since 1st October 2021. Both organisations would like to offer assurances to the coroner, surrounding the transfer process. GMMH commenced the decommissioning process approximately ten months prior to the official handover, having made an organisational decision not to bid for the new contract.
The decommissioning process included regular internal (GMMH) and external (Humankind) meetings, agreement of information governance arrangements to enable a safe transfer of clinical data, the development of guidance in the management of incidents, investigations and inquests, post transfer and the sharing of clinical pathways, local procedures and complex case reviews completed by both organisation's medical leads.

From our meeting we understand Humankind are developing their own response to the issues raised in your report and how they will take these forward within their organisation.

Under the circumstances, GMMH would like to offer an opportunity to meet with coroner Ms Cheema to discuss the transfer of addiction services to a new provider and the ongoing response of services during the COVID-19 pandemic. However, we do appreciate that, given the Trust are no longer the provider of Community Addiction Services in Cumbria, this offer may be more appropriately directed to Humankind, or indeed a three-way meeting may be considered.

Dr Shaw, on behalf of the Trust can I thank you for bringing these matters of concern to the Trust's attention. I hope this response demonstrates to you and Mr Lawrence's family that GMMH have taken the concerns you have raised seriously. If you have any further questions in relation to the Trust's response, please do let me know.

Yours Sincerely,

[redacted]

Dr [redacted]
Medical Director
[redacted]