[redacted]

Green Porch Medical Centre

Primary Healthcare Provider

Bina Patel
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RE: Regulation 28 Report to Prevent Future Deaths

Natalie Mortimer (died 21.04.2022)

Dear Mrs. Patel

Thank you for your report dated 25th July 2022.

You have requested a response to this report containing details of action taken to prevent future deaths.

The above patient died on the 21st April 2022 due to multi-organ failure as a result of colchicine overdose. This was originally issued in November 2021 for treatment of gout.

The above patient had a history of depression and anxiety and had an attempted overdose previously in April 2021. This was not read-coded on the system and no alerts were in place within the system to highlight this.

We have reviewed this case in depth and have put the following steps in place to ensure that this does not happen in the future.

1. We have employed a full time read-coder, who will ensure that all letters are properly read-coded and alerts put on patient records when necessary. The Read-coder will have the appropriate training to ensure that this is being maintained to the highest standard. This will ensure that the appropriate letters are sent to the appropriate member of staff. We plan to deliver refresher training to existing coders and all new coders to undergo extensive training prior to coding.

2. We have introduced a correspondence triage policy/flow chart – please find

attached – This will ensure that the relevant details are passed on to the most appropriate member of staff for example a clinician will see all letters regarding overdoses and suicide attempts in future.

3. We now have a system in place to ensure that relevant important alerts are put on the system for individual patients. This will initiate as soon as somebody logs into the records and an alert message will inform the clinician/administration/reception team what the concerns are. This will be on the screen until it is confirmed as acknowledged. Alerts will be in place for overdose attempt/Safeguarding issues/suicidal ideation/domestic violence etc.

4. We have encouraged all clinicians to use the Arden templates for reviewing depression. Asking the patient about self-harm is incorporated as part of the template. This will also help to ensure patients safety as it automatically flags up as a read-code. i.e., history of self-harm/suicidal ideation/Overdose attempt etc.

5. We have had a meeting with the CCG/ICB Medicine Management team regarding this case, due to the fact that the default prescription for colchicine is for 100 tablets. This has been raised on a local level and has been changed on the system for local practices. Additionally, they have raised this on a national level via SBAR (see enclosed) and recommended the following:
   - Add quantity limiter to script Switch and limit prescribing to 12 tablets at a time.
   - The team would like to communicate this case study to all clinicians in the Kent and Medway area via the GP bulletin. This is published by NHS England Primary care. The bulletin is usually sent once a week and is for teams across general practice, dentistry, community pharmacy and optometry.
   - Remove the quantity of 100 (Pack size) from all EMIS formularies in GP practices.
   - Add warning information message to script Switch regarding the toxicity of colchicine and be aware of the risk of overdose in the care of patients with a history of mental health issues.

6. We have put alerts on patient records for anyone requesting colchicine (see example enclosed) regarding the toxicity to ensure that this is explained to the patient at their next review. The alert recommends limiting the colchicine to 12 tablets and if there is a history of Mental health, depression, Suicide attempt or self-harm, to carry out a risk assessment before issuing.

7. We are currently in the process of auditing of Docman to ensure quality compliance i.e., read-code is appropriate, that the relevant team has seen the document, any follow ups completed, any concerns raised with the relevant department etc. Audits will be carried out every 3 months, starting 1st of December 2022.

Thank you for giving us this opportunity to respond. We have learned from this incident and raised this internally has a significant event, as well as raising this with the CCG/ICB to disseminate the message more widely in Kent and beyond. Important changes have been made for the safety of patients in the future as a result of Ms. Mortimer's death. We hope that this will be of some small consolation to her family in their loss.

This has been discussed at a clinical meeting to ensure that this does not happen again in the future.

Yours sincerely

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Enclosures
New work flow for incoming correspondence
SBAR
Screenshot of alert for colchicine