



HM Coroner Oliver Longstaff
71 Northgate
Wakefield
WF1 3BS

Your Ref:

PFD report Burton Croft Surgery

Date:

24 May 2023

Dear Mr Longstaff

**Inquest touching upon the death of Aoife Rose McAdam
Incident Date: 4 September 2021**

We write on behalf of [REDACTED] and the Burton Croft Surgery in relation to a Prevention of Future Deaths report dated 27 March 2023 that was issued by you to the Practice following the Inquest touching upon the death of Aoife Rose McAdam, which took place on 24 March 2023.

We set out below the steps taken and the actions still to be taken by the Practice.

Actions taken prior to Inquest

There were no Practice wide policies in place at the time of Miss McAdam's death.

The medicines team at the CCG hold quarterly safer prescribing update meetings and the HSIB Safety Investigation was not discussed with GPs in the Leeds area during any of these meetings, to Dr Gibson's knowledge, until after Miss McAdam's death.

After Miss McAdam's death in September 2021, [REDACTED] contacted the prescribing team at the CCG. Propranolol toxicity in overdose was therefore discussed at a subsequent CCG prescribing meeting.

An alert is now in place on all computer systems in Leeds GP practices such that when a prescription for propranolol is raised, an alert reads:

"Ensure the risks are assessed for this patient; propranolol should only be used with caution in patients with depression, anxiety or migraines".

This is called an Optimise Rx alert - Optimise Rx is a clinical decision support tool which is integrated with GP computer systems. It is a prescribing support software tool which delivers patient specific messages at the point of care ensuring appropriate and safe prescriptions.



Optimise Rx is tailored to the medical record and considers the patient's current and past medications, morbidities, observations and measurements to support prescribers to make the safest, most clinically appropriate prescribing decision.

Further, on this Optimise Rx alert there is Source details where the HSIB reference information can be viewed. There is also a mention of referring to NICE guidance (CG113; July 2019).

At the time of Miss McAdam's death there were no specific practice policies in place for locum GPs relating to propranolol prescribing at Burton Croft Surgery, particularly in relation to the amounts prescribed.

A Significant Event Meeting/internal review was held at the Practice on 17 November 2021. This meeting was attended by partners, nurses, managers and GP trainees. Minutes of this meeting were subsequently circulated to the whole Practice team.

Miss McAdam's death was also discussed in relation to propranolol prescribing. The HSIB report was discussed. This Significant Event was also escalated on a proforma called Datix to the CCG with the outcomes of the Practice's in-house meeting and changes to practice.

The main outcomes of the Significant Event Meeting were as follows:

- That the dangers of propranolol overdose should be discussed with each patient and an assessment made as to the pros and cons of prescribing. Where prescriptions are deemed to be indicated, propranolol will be issued on an acute prescription, not to exceed 10mg three times a day as required for a week. Therefore, no more than 21 tablets would be issued at an initial appointment. A follow up appointment would then be scheduled to take place no more than 2 weeks later;
- The Practice devised their own prescribing alert which read, *"dangerous in overdose as slows the heart and can result in death if exceeded"*;
- This alert was superseded by the alert already mentioned which was set up by the CCG with a link to the HSIB reference information of 2020 (The Optimise Rx alert); and
- The locum welcome pack was also updated after this meeting on 14 December 2021. The pack includes a section on prescribing. It reminds locum doctors of the importance of using the CCG prescribing alert facility as a decision support tool around drug safety (Optimise Rx).

Action taken since the Inquest

Since the Inquest took place on 24 March 2023, [REDACTED] and the team at Burton Croft Surgery have been working hard to ensure that as much as possible has been done to ensure the prevention of any further deaths in these circumstances.

The following steps have been taken:

1. The Practice Repeat Prescribing Policy, enclosed as **Appendix 1**, was updated on 9 May 2023, and at page 10, you will note a section, under the heading "Review Process" which states as follows:

"When conducting medication reviews or discussing any form of change in medication, clinicians should ALWAYS ask patients whether they have any unused medication in their supply. Patients should always be advised to dispose of any unwanted or unused medication safely by returning it to the nearest Pharmacy."

2. Burton Croft Surgery have tried to amend the depression template used at the Practice to add in a warning about the safe storage, management and disposal of anti-depressant and beta blocker medication. It is technically not possible to amend the Ardens templates at local practice level.

By way of explanation, a company called Ardens create and distribute templates for use nationally in GP Practices. On 26 April 2023, the Practice sent an email to Ardens asking them to include an additional tick box on the depression template with the suggested wording, "patient advised of safe storage, management and disposal of anti-depressant medication". The Practice had hoped that this tick box would be added to national templates used by GPs.

We enclose a copy of the email chain with Ardens as **Appendix 2**. You will note that Ardens have responded, stating that they would take the Practice request into consideration at their next development meeting. To date, there has been no further response from Ardens.

In the meantime, the Practice is using the sno med code 2974640010 'education about safe storage and management of medication' and the Practice is using it specifically in patients with mental health problems when they are prescribed propranolol and antidepressants. The use of this code will allow the audit to take place in February 2024 as set out below.

A reminder, in the form of a typed sticky note, has also been attached to the front of all Burton Croft Surgery computers, to remind clinicians to advise patients about the safe disposal of unused medication. The sticky notes states:

"Beta blocker/anti-depressant medication"

EMIS Code:

'Education about safe storage and management of medication'

Patient must be told to return their unused medication to the pharmacy –put in EMIS notes"

3. On 27 April 2023, an email was sent (enclosed as **Appendix 3**) to all clinicians, including GP trainees, advising that all clinical staff needed to ensure that a code entitled "Education about safe storage and management of medication" was added into the EMIS notes when the clinicians were prescribing/changing/discussing beta blockers or anti-depressant medication.

In the same email, clinicians were also advised to inform the patients that they must return unused medication to the pharmacy when clinicians are told that the patient is no longer taking a medication and that a note must be made on the patient record that this advice has been given.

4. A further Significant Event Meeting took place on 10 May 2023. We enclose a copy of the minutes of this meeting as **Appendix 4**. As you will note, the main focus of this meeting was the PFD report and the steps the Practice needs to take/has already taken in respect of improving safety around medicines.
5. [REDACTED] have been working on an update to the locum pack. The updated pack is now in use at the Practice and includes a section on returning unwanted medications. It has also been distributed to all GPs/GP Registrars and locums. We enclose a copy of the relevant section of the updated Locum Pack at **Appendix 5**.
6. The Practice website was updated on 2 May 2023. Under the "Order a prescription section", the Practice has created a new heading in red type "Returning unwanted or out of date medication". This section then states as follows:

"We kindly ask that our patients do not hang on to medications if they are no longer needed and to please drop them in to a local pharmacy for safe disposal."

We enclose a screen shot of the relevant section of the Practice website at **Appendix 6**.

7. The Practice has contacted 19 local pharmacies by email, asking them to raise awareness of the importance of returning unused medication to a pharmacy amongst their patients. The Practice also asked the pharmacies if they could share any posters or on-line material regarding the return of medicines with the surgery.

We enclose a spreadsheet detailing which Pharmacies have been contacted as **Appendix 7**. We also enclose a copy of the email sent to the pharmacies, dated 4 May 2023, as **Appendix 8**.

Action still to be taken

1. The Practice is currently working on a text to be sent to all patients in relation to the completion of a medication review questionnaire and the Practice has added a new section at the bottom of this text in relation to returning unused medication.

The Practice has not yet decided how it will use this tool and will be further refining it. However, a text of this nature was discussed at the SEA meeting on 10 May 2023 and this will be progressed further.

2. The Practice intends to put posters up in reception and in the waiting room asking patients to ensure that unused medication is returned.

These posters have now been printed in colour and laminated and will be put up this week.

3. Practice has not yet audited the use of the sno med code described above. The Practice is going to carry out this audit around February 2024 with one member of staff conducting the search and [REDACTED] interpreting the results. This search has already been set up in preparation for the audit. The audit will then be discussed at the Practice's monthly SEA meeting.
4. The Practice is awaiting the response from Ardens in relation to the proposed change to the national template for depression used by GPs as set out above.
5. The Practice will contact the two outstanding pharmacies once they have a contact email address for them as per point 7 under the heading "Action taken since the Inquest" above.
6. Finally, [REDACTED] received an email dated 10 May 2023 from [REDACTED] from the medicines safety, governance and assurance team at West Yorkshire ICB. This email states as follows:

"I know at the time you worked with me and a colleague to take steps to raise awareness across other practices in Leeds e.g. getting an Optimise Rx message in place & sharing a safety snippet in the primary care bulletin to alert prescribers to the risks with propranolol. I also brought it to the attention of the West Yorkshire ICS Medicines Safety Group so colleagues in other local trusts/CCGs (at the time) were aware of the risks and they chose to activate the Optimise Rx message too. Hopefully this is a useful reminder of the actions taken outside of your practice in case you wished to include this in your response?"

But in light of the report, I think it would be worth me sharing further comms via the bulletin (and possibly Community Pharmacy West Yorkshire bulletin too) about importance of returning unwanted meds in particular? If you have any other suggestions, please get in touch."

Clearly, the ICB's plan is to raise awareness of the PFD report received by Burton Croft Surgery via the Primary Care bulletin and possibly also the Community Pharmacy West Yorkshire bulletin.

[REDACTED] responded to [REDACTED] on 11 May 2023 but is yet to receive a response. [REDACTED] will continue to liaise [REDACTED] about this.

Conclusion

Miss McAdam's death has greatly upset all of the doctors at the Practice.

[REDACTED] as Senior Partner of the Practice and all of the staff at Burton Croft Surgery have worked extremely hard to take immediate action to ensure that a future death of this kind is prevented which we hope is clear from this response to the Prevention of Future Deaths report and the enclosed Appendices.



If you have any queries please do not hesitate to contact us.

Yours faithfully

DWF Law LLP

DWF Law LLP