THE LIMEHOUSE PRACTICE

[redacted]

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29th January 2024

Mr Ian Potter
HM Assistant Coroner
Inner North London
Poplar Coroner's Court
127 Poplar High Street
London
E14 0AE

Dear Mr Potter,

Regulation 28 Report to Prevent Future Deaths

I write on behalf of the partners of the Limehouse Practice to respond to your Prevention of Future Deaths Report dated 17 November 2023.

Firstly, the partners and I would like to offer our condolences to Mr Lockwood's family following his sad death.

The Limehouse Practice serves a population of around 11,500 patients in Tower Hamlets, looking after a diverse group of patients, with high rates of poor mental health and often facing significant economic adversity. A particular characteristic of the practice is that it also serves a large number of hostels, including the largest women's hostel provision in the borough, as well as a refuge for south Asian women, a supported living facility supporting adults with learning difficulties. Several other hostels within the Practice area provide accommodation for a large number of adults with high rates of substance misuse, a history of trauma and adversity, and facing poor mental health and psychosocial challenges.

As a Practice we have worked for many years along with the local drug and alcohol service to provide excellent care for our patients who face difficulties with drug and alcohol use. The experience of the partnership and team at the Limehouse Practice supports this work.

Opiate substitute treatment is only prescribed by doctors within the practice who have completed at least part 1 RCGP substance misuse training, and this is something we encourage all doctors at the Practice to achieve.

We operate a personal list system and each prescribe opiate substitute therapy to the patients on our own list to ensure continuity or care. We also believe the continuity of personal lists assists in the safe management of high risk and complex patients within the Practice.

We also have a substance misuse key worker employed by RESET, the local drug and alcohol service, who operates a satellite clinic at the Practice. We only prescribe opiate substitute therapy to patients as part of shared care with RESET.

We have 2 network employed pharmacists based at the Practice who have supported us in monitoring high risk drug prescribing, including prescribing of drugs with a potential for abuse.

There are four partners and four salaried GPs at the Practice. Three of the partners are GP trainers and also have other roles outside the Practice. I have a special interest in alcohol and

substance misuse, having completed part 1 and 2 RCGP substance misuse training. I am the locality lead for primary care drug and alcohol management, supporting local practice teams in managing patients with drug and alcohol problems and providing physical health checks for this vulnerable patient group. I also train GPs and other primary care team members in alcohol management in primary care as an approved alcohol trainer for the RCGP.

We note that the conclusion of the inquest was that Mr Lockwood's death was a drug related death, the medical cause of death being:

1a – hypoxic brain injury, multiple organ failure and bronchopneumonia following cardiac arrest.
1b – mixed drug toxicity.

We also understand that you found that the overdose that led to Mr Lockwood's admission to hospital on 14 April 2023 was like to have been a heroin overdose.

We have and continue to consider the concerns raised seriously and respond to the two concerns raised and summarised below:

1. That the evidence you received during the inquest did not reassure you that sufficient steps were taken for signs of Pregabalin abuse, particularly in a patient with known history of drug abuse.
2. The statement from Mr Lockwood's named GP alluded to the fact that there were possible record keeping issues surrounding Mr Lockwood's prescriptions for Pregabalin. A Serious Event Analysis (SEA) was conducted but, as there were errors in the original SEA, we decided that the SEA needed to be re-opened and revisited. You were not reassured that the relevant risks have been fully explored and acted upon.

We have undertaken a further SEA, and this has been completed with agreed actions.

<u>Prescription of Pregabalin and monitoring for signs of abuse:</u>

We are aware of the recommendation in the British National Formulary that Pregabalin should be monitored for signs of abuse.

All patients have medication reviews and those patients who are known to have problems with substance misuse are be invited to have an annual substance misuse health check which would involve physical health checks carried out by an HCA / nurse followed by a comprehensive review of physical and mental health by the registered GP.

We were aware of the recommendations made by CGL (the drug treatment provider at the time) in August 2021 that care should be taken when prescribing other medications for Mr Lockwood that may have misuse potential, for example Pregabalin. Since prior to registering at the Practice in 2021, Mr Lockwood had been receiving a prescription of Pregabalin, which was issued at 4 weekly intervals. This continued with the knowledge and recommendation of RESET, who were managing the patient's substance misuse including prescribing him methadone.

Until December 2022, Mr Lockwood continued to receive prescriptions for Pregabalin at four weekly intervals when the duration was changed to two weekly. There had been no previous incidences of early requesting of Pregabalin, or concerns that the patient was misusing or over-using this medication.

Between December 2022 and 26 January 2023 there were further reviews of the Pregabalin.

In December 2022 Mr Lockwood was reviewed and he reported increased anxiety symptoms. The GP suggested this dose increase as a response to Mr Lockwood's reported increased anxiety. The dose is within the BNF recommended ranges, and this medication was prescribed for anxiety, one of the licenced indications for this drug. This does therefore seem a reasonable course of action. That doctor reduced the length of the prescription to two weeks instead of the usual four weeks.

There was a mistaken concern on 17 January 2023 that Mr Lockwood had requested the prescription for Pregabalin early (after two weeks rather than four weeks). It would be appropriate to reject any prescription, particularly for a controlled drug or a drug with potential for addiction, if this is requested early, to avoid the patient over-using and being exposed to the risks of overdose. This would have been in accordance with the recommendations of CGL in August 2021 to monitor for signs of abuse.

As we have identified in the SEA, between 17 January 2023 and 26 January 2023 three doctors were involved in reviewing and altering the prescription for Pregabalin with a view to reducing the tablet burden and address the reported increasing anxiety. Unfortunately, there was some confusion and lack of clarity about the prescribing (which I will deal with further below).

After 26 January 2023 Mr Lockwood was not seen face to face again at the Practice prior to his death on 2 June 2023, although the Practice made 4 attempts to contact him to invite him (on three occasions for a substance misuse health check, which would involve physical health checks carried out by an HCA / nurse followed by a comprehensive review of physical and mental health (including an assessment of abuse of the medication) by the registered GP, and on one occasion to invite him for immunisation) in the intervening period. He did continue to receive his Pregabalin prescriptions at regular 4 weekly intervals.

We were also made aware that Mr Lockwood had been admitted to hospital on 16 February 2023 having taken an overdose of clonazepam and diazepam. We attempted to contact Mr Lockwood
on 24 February 2023 and 6 March 2023 but the phone did not connect.

Record keeping issues

As part of the SEA we have established that the reasons for the change in the dose and the frequency of the prescription of Pregabalin between December 2022 and January 2023 was not clearly documented in the records meaning that there was an element of confusion for both the reviewing GPs and, most likely, Mr Lockwood.

Action taken by the Practice

As set out in the SEA we have taken the following steps to address the concerns which you have identified:

1. We will ensure 3 monthly face to face reviews for patients on Pregabalin, gabapentin, benzodiazepines, oxycodone and other dependence inducing medications.
2. We are carrying out a search to identify all patients on Pregabalin/ diazepam or similar medications who are also prescribed opiate substitute treatment, either at RESET or in shared care. We will carry out a medication review for those patients and discuss with RESET and

the possibility of them prescribing of opiate substitute medication as well as other medications with potential for dependence if appropriate.

3. If any changes are made in doses of medication or tablet strength, this must be documented in EMIS consultation notes so there is a clearly identifiable rationale for any change. Patients should also be notified of any change in drug dosage / tablet strength.
4. Protected Learning Time is to be used to provide refresher training to all prescribers about EMIS prescribing function and how to view previous medication issues / amendments, as well as further training on prescribing drugs with potential for dependence. I have contacted the CGL/RESET consultant and am awaiting a response from them about agreeing a date for training.
5. All prescribers to undergo further training on prescribing drugs with potential for dependence.

Unfortunately, we did not receive any further information from the hospital or notification of Mr Lockwood's death until a letter dated 30 June 2023 was received from the Senior Coroner's officer on 3 July 2023. At that stage we were unaware of the medical cause of death to allow us to consider arranging for an SEA to be carried out. We only received details of the medical cause of death following the conclusion of the inquest. We have taken steps to ensure that requests for reports and correspondence with the Coroner's office are brought to the attention of the partners so that we can ensure that all matters relevant to the Coroner's investigation and inquiry are dealt with and that, where appropriate, we can arrange for an SEA to be undertaken in a timely manner.

I hope this information provides you with reassurance that your concerns about the risk of future deaths have been addressed.

Yours sincerely

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[redacted]

GP Partner & on behalf of:

[redacted] **– GP Partner**
[redacted] **– GP Partner**
[redacted] **– GP Partner**