KIRBY ROAD SURGERY [redacted]

Practice Response to Regulation 28 Report to Prevent Future Deaths.

To the Chief Coroner:
We write in response to the Regulation 28 report dated 02.01.2024 from Sean Cummings, Assistant Coroner for Bedfordshire, and Luton Coroner Service.

Mr Cummings commenced an investigation into the death of Mrs Joy Ebanks aged 59, which concluded on the 13 December 2023. The medical cause of death was identified as due to oxycodone and pregabalin toxicity.

The Coroner found that the circumstances of death were as follows:
Mrs Joy Ebanks lived alone, she had been self-neglecting and not engaging with support services. She suffered from Fibromyalgia, arthritis and agoraphobia. She had been diagnosed with depression and was prescribed both venlafaxine and quetiapine. She used cannabis. Mrs Ebanks had been prescribed opiates since 2009. Her medications at the time of death included long-acting morphine -Longtec 100mg twice daily together with Pregabalin 150mg twice daily. She had been on this dose since 2014. There were periodic supplementations with Shortec 5mg 1-2 tablets up to four times daily (112 provided). The reason for the prescription was for fibromyalgia and "chronic pain" (undefined). Because of her agoraphobia and a dislike of people coming to her home, medication reviews were undertaken largely by telephone.

The Matters of Concern raised by the Coroner were as follows:
1. There was evidence of very prolonged prescribing of two dependency forming drugs with no evidence to suggest that a discussion had been had or plan had been formulated to reduce the dosages.
2. The Guidance for Prescription Drug Dependency used by the practice highlights the hazards and limited utility of long-term prescription of opioids for chronic pain. It also highlights the poor evidence base for use of gabapentinoids in these circumstances.
3. The primary cause of death was 1a Oxycodone toxicity enhanced by pregabalin intake.

Kirby Road Surgery Response:

Kirby Road Surgery are deeply saddened by the passing of Mrs Joy Ebanks and our sincerest condolences are with her family and friends.

We are proactively utilising the learning opportunities that have arisen from these circumstances to deploy effective measures of improvement to mitigate future incidents and uphold patient safety.

The practice promptly initiated an investigation and conducted a significant event analysis (SEA) to understand the root causes of the incident. For full information pertaining to our SEA (including the outcome of our root cause analysis), please see **Appendix 1- Significant Event Analysis (SEA) Form.**
The Surgery also contacted Bedfordshire, Luton, and Milton Keynes Integrated Care Board (BLMK ICB) Medicines Management Team and Quality Team for advice and guidance, and to develop a robust approach to the issues which could then be presented for wider scale use across all Bedfordshire, Luton, and Milton Keynes (BLMK) practices. This will enable other BLMK practices to support their own work with patient cohorts, further promoting patient health, wellbeing, and safety on a wider scale.

This case was also discussed at organisational meetings which included: Quality Assurance Meetings, Clinical Team Meetings and Opioid Monitoring Meetings to share information, facilitate learning and enable staff to develop and deploy actions and improvement. For full details of these meetings, who they included and a summary of what was discussed, please refer to **Appendix 2- Quality Improvement Monitoring Form.**

Our Clinical Lead Pharmacist identified, and risk scored all patients on opioid medications and also those on gabapentinoid medications to determine and recall individuals for a face-to-face structured medication review within a 28-day time period. These patients were then sent letters to inform them that their medication would be undergoing an upcoming review with a specialist prescribing pharmacist.

These face-to-face structured medication reviews with our specialist prescribing pharmacist have already commenced, with a high patient uptake. Those patients who are housebound are receiving a home visit from the same specialist pharmacist.

A structured medication review consists of:

- An assessment of the patients' condition (s).
- A discussion to determine their experiences of pain and their pain scores.
- A review of their medication including when this was initiated and why.
- An exploration of what additional support may be required to promote good health and wellbeing, such as onward referrals to specialty services (including orthopaedic and pain management clinics) as well as mental health services.
- A structured plan being implemented so dose reduction can commence safely with 2 weekly follow up.
- Some patients would also require a review of their mental health support medication.
- Opioid prescribing agreement implemented with patient cooperation.

All patients will undergo a follow up every 2 weeks with our specialist pharmacist.

The Partners and Management Team sourced and recruited a specialist prescribing pharmacist (who has extensive experience of working in a pain clinic) to undertake the face-to-face structured medication reviews. Three of our inhouse clinical pharmacists are also undergoing training with our specialist prescribing pharmacist to enhance their skills and knowledge in this area to perform these reviews in the future.

The Partners and Management Team sourced further training courses regarding opioid awareness, which has been approved by the BLMK Integrated Care Board (ICB). These courses include:

- 'Reducing opioid prescribing for chronic pain'- introduces chronic pain, NICE guidelines, opioid efficacy with chronic pain and the adverse effects of opioids.
- '10-minute CBT for persistent pain'- involves training in effective skills for better supporting people with chronic pain in primary care.

All clinical members of staff have undertaken these courses. For more details, please refer to **Appendix 2- Quality Improvement Monitoring Form.**

Our Opioid Prescribing Policy and our Gabapentinoid Prescribing Policy underwent updating and review by the Quality Assurance Manager to ensure all information was up to date. This was further reviewed by BLMK Medicines Management Matthew Davies to ensure compliance. Once recommended actions were implemented into policy, this was then signed off and ratified by

members of staff in two clinical team meetings. For the **Opioid Prescribing Policy, please see Appendix 3**. For the **Gabapentinoid Prescribing Policy, please see Appendix 4.**

Information from the updated Opioid Prescribing Policy and the Gabapentinoid Prescribing Policy has been uploaded onto the health hub section of our website, under the new section 'High- risk medications.' This section also provides information about medication dependency, their dangers, helplines patients can consult and helpful leaflets.

The actions documented above reflect a commitment to learning from past events and continuously improving the quality of care provided to patients as well as our dedication to improving patient safety.

We believe that the robust measures taken (as summarised above) will greatly enhance patient safety for those on high risk medications and continue our delivery of high quality and safe care.

This case and action plan will be reviewed on the 11 March 2024 and again on the 15 April 2024.