NHS
Greater Manchester
Integrated Care

E: [redacted]

Date: 25 November 2024

Private & Confidential

Ms Alison Mutch
H M Senior Coroner
1 Mount Tabor Street
Stockport
SK1 3XE

Sent by email to: [redacted]

Dear Ms. Mutch

Re: Regulation 28 Report to Prevent Future Deaths - Paul Michael Clark

Thank you for your Regulation 28 Report dated 16 October 2024 regarding the sad death of Paul Michael Clark. On behalf of NHS Greater Manchester Integrated Care (NHS GM), We would like to begin by offering our sincere condolences to Mr. Clark's family for their loss.

Thank you for highlighting your concerns during the inquest which concluded on the 8 October 2024. On behalf of NHS GM, we apologise that you have had to bring these matters of concern to our attention. We recognise it is very important to ensure we make the necessary improvements to the quality and safety of future services.

During the inquest you identified the following cause for concern: -

> **The Inquest heard evidence that Paul Clark had previously been addicted to heroin. He had been successful in treating his opioid addiction and had remained opioid free for many years. His previous problems with opioids and the risk of opioids for him were well documented within his medical notes. However, despite the risks opioid painkillers presented to him, he had been started in primary care them at increasing levels, topping them up with non-prescribed opioids. There was no evidence before the inquest that the inherent risks of reintroducing opioids to someone who had previously been addicted to them were considered or monitored.**
>
> **It was accepted in evidence that whilst opioid pain killers can be helpful for treating some patients, the risks of treating a patient with a former opioid addiction with opioids were significant and that there needed to be a very thought out rationale with careful monitoring to avoid increasing the chances of a patient relapsing into addiction through GP prescribed medication and that it was essential that GPs considered this when prescribing.**

The Electronic Medical Information System (EMIS) clinical system is a digital platform designed to manage and store patient health information electronically, facilitating improved healthcare delivery and record-keeping. This system enhances the efficiency of medical practices and allows for better patient care through easy access to medical records and data sharing among healthcare providers.

EMIS enables GPs to input a pop-up message / warning to alert clinicians to important information about an individual patient. Once an alert is set up, the message appears immediately that the patient record is accessed. Following the inquest, I can confirm that Archwood Medical Practice have undertaken an audit of their patient records to identify all patients with a history of drug addiction. A 'pop up' alert will be added to each identified record to ensure that anyone consulting with a patient within this cohort is immediately aware of the history and can therefore consider this history within their clinical decision making.

I can confirm that all GPs within Greater Manchester have access to guidance in the prescribing of opioid medications; this can be accessed via the following link:
https://gmmmg.nhs.uk/wp-content/uploads/2023/12/Opioid-resource-pack-2023-final-for-web.pdfecific

In addition further national guidance is available via the National Institute for Health and Care Excellence:

https://www.nice.org.uk/guidance/ng215
https://www.nice.org.uk/guidance/ng193

In order to support our wider GP population, a Masterclass presentation on the subject of opioid prescribing was delivered to Stockport GPs and clinicians on 12 September 2024. The session title was 'Pain Transformation, IMPS and Opioid Stewardship'. A total of 62 clinicians attended the session which was delivered by Dr Thomas Walton, Consultant in Anaesthesia and Pain Management.

The Regulation 28 report and our response will also be shared, in January 2025, for system learning with the GM cross-sector medicines safety group - the IPMO Medicines Safety Group. This group reports to the Greater Manchester Medicines Management Group (GMMG) and is co-chaired by NHS GM and Manchester University NHS Foundation Trust (MFT). The intention is to reflect on any learning from the Regulation 28 report and create a 7-minute briefing to be produced, disseminated to clinical staff and used for shared learning.

I hope the above information is helpful to you but if you do require any additional information, please do come back to me.

Best wishes

[redacted]

[redacted]
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