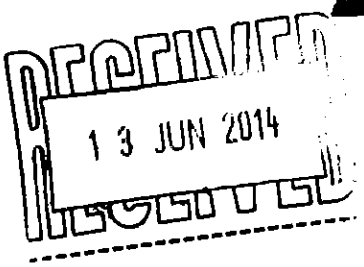
TELEPHONE: [redacted]
FAX:



MUNDESLEY MEDICAL CENTRE
MUNHAVEN CLOSE
MUNDESLEY
NORWICH
NR11 8AR

Ref: CA/HAH

Dictated on: 06 Jun 2014
Typed on: 06 Jun 2014

[redacted]
Coroner's Office Norwich
69-75 Thorpe Road
Norwich
NR1 1UA

Dear [redacted]

Regulation 28 Notification, Mr Darren Lee Arnoup

Thank you for your recent correspondence and a request for a response from Mundesley Medical Centre regarding a Regulation 28 Notification.

We welcome the opportunity to review primary care procedures that may benefit patient care.

We recognise that your primary concern was that 2 letters from the Colman Centre, Colman Hospital, Specialist Rehabilitative Services (dated 21.05.13 and 12.06.13) highlighting a suicide risk were not read by a GP.

We have reviewed the course of events in detail.

On 25.09.12 Alison Woods (Clinical psychologist, Colman Centre For Specialist Rehabilitative Services) left a message for [redacted] informing him that Mr Arnoup had attempted suicide the previous day. Apparently he had prepared a piece of rope but had stated that he did not want to commit suicide but wanted people to know how desperate he was.

In response, [redacted] arranged and conducted a telephone appointment with Mr Arnoup on 29.09.12 and recorded that Mr Arnoup was less tense about his employment problems.

The Colman Centre also wrote to Mundesley Medical Centre on 2 occasions.

Contd over/.....

[redacted]

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Re: Regulation 28 Notification, Mr Darren Lee Arnoup

1. A neuropsychological report from the Colman Centre dated 21.05.13, makes reference to the suicide attempt in September 2012. This report was not passed to a GP as it was documenting historical information and it goes on to say "at this time (ie May 2013) Mr Arnoup denied any intention to kill himself".

2. We received a copy of a letter (as did Norfolk Recovery Partnership, NRP) on 12.06.13 from the Colman Centre addressed to the Access and Assessment Team (AAT) mental health care trust. This documented previous self-harm and suicidal ideation; however as a referral was being made between the 2 agencies (the Colman Centre and the AAT) and only being copied to the GP with no action indicated, this was filed by an administrator. In addition, Mr Arnoup had been assessed by the AAT on 06.09.13 and there was no mention of any past or current suicidal ideation or deliberate self-harm in a letter to Mundesley Medical Centre. No formal follow up was arranged by the AAT but he was directed to self-referral into the Wellbeing Service if required. If at this point this letter had alluded to a current risk of suicide or required any action for onward referral by the GP, this letter would have been passed to a doctor for review, rather than reviewed by an administrator and filed.

As well as reviewing and reflecting on our internal processes, we also decided to request an external medical records review by Jackie Schneider, Head of Quality and Patient Safety at the CCG. This is enclosed for your perusal.

Her recommendations which are listed below will be implemented.

Recommendations for consideration

1. Develop clear lines of communication with NCH&C staff to ensure that where they feel that relevant details have been documented within the shared record that they believe GP/Practice should be party to and that they ensure they alert and where possible summarise actions/concerns for clarity.

2. Due to the nature and impact of Mental health illness and substance abuse upon physical health and variability of risk factors and coping strategies for patients, if other professionals contact the practice to inform that a referral has been made in relation to these areas the GP should be alerted so that any subsequent consultations can be undertaken with this awareness. Safeguarding/Domestic violence concerns highlighted should also be managed in the same way.

Contd over/.....

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3. Where other medical input highlights substance misuse (i.e. reports following admissions) this could impact upon the support or prescribing offered at future practice consultations therefore consider making GP/nursing staff aware.

4. While understanding the limited timeframe of appointments and therefore ability to document consultation details, ensure that GP's make as full a history of any areas of mental upset or likely personal life instability discussed for the information of successive colleagues.

In addition we have amended our procedures and protocols as summarised below:

1. A GP will always be informed if a referral is made directly to the mental health service from an outside agency.

2. In consultation with a patient with mental health problems or those already under the care of the mental health service, a GP will review any relevant documentation, reassess the risk of self-harm, consider onward referral to the mental health service and record this in the medical record.

3. We have highlighted to all staff the importance of sharing information about vulnerable people at risk of suicide and deliberate self-harm and such correspondence will now be shown to a GP.

4. We are reviewing the use of filters on the SystemOne computer system, to make sure that relevant information is visible to the user.

This case has highlighted the problem with the amount of data and how it is shared within the wider NHS. It is evident that the CCG have concerns about how other organisations inform us of 'at risk' patients. A clear summary of findings or actions taken is usually difficult to identify.

This sad case has provided an opportunity for us to close any gaps and continue to strive to provide the best care for our patients. We understand the concerns of the family and the coroner and our ultimate aim would be that this review would help prevent any future deaths.

Contd over/.....

[redacted]

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Re: Regulation 28 Notification, Mr Darren Lee Arnoup

If there are any areas in our reply that you feel that we have not addressed, please contact us again.

Yours sincerely

[redacted]

[redacted]

[redacted]

[redacted]

[redacted]

NHS
North Norfolk
Clinical Commissioning Group

Mundesley Medical Centre Medical records system review

Process

Currently clinical records at Mundesley Medical Centre are electronically maintained within SystmOne which provides a shared recording system across participating clinicians and organisations, in this instance the GP practice and staff employed by NCH&C.

While the system allows multi-professional input, depending on patient permissions sought and provided and any filters applied this can lead to entries being made, but which may not be available to be viewed by others. This may mean that the practice are not aware that consultations have taken place or their outcomes.

Internally the practice provides a slick process of managing information and letters that are sent to them. All reports are "scanned up" and read fully by experienced medical secretaries who identify actions or current clinical/safety issues which have been raised within the reports with 1 working day of receipt. They are then raised as actions to relevant clinical staff for them to acknowledge and confirm that the issues have been noted or completed. However this would not capture information which has been added to systmOne by other participants.

Many of the reports and information received by the practice is long and detailed. It is accepted that for clinicians to undertake the role of fully reading all reports and letters received would have a serious impact upon their patient facing time and may result in details/actions being missed as they can become difficult to pull out of the body of reports if not thoroughly reviewed.

Relevant issues

- Within the case reviewed it was evident that the Practice had some low level intermittent involvement with the patient, while the Neuro-rehab team (NCH&C) had been actively consulting with the patient and his wife for a number of months, however as there was no alert to the practice regarding the frequency, level or outcomes from their input it would have been unlikely that the practice would have recognised the need to note or review details being recorded.

- In June the Neuro –rehab team wrote to the GP to inform that they had made a referral for the patient re: a mental health assessment and a referral to Norfolk Recovery Partnership for support with Alcohol misuse. Within the body of the letter comments were made regarding the patients previous risk of self-harm from some years earlier. As the letter indicated this was an historical problem and that referral to Mental health and NRP were being made, this information was not actioned for the GP to review as it was felt there was no further action required by the practice at that point.

- The patient had been admitted to hospital as an emergency on 3 occasions, on each occasion the discharge letter was summarised and entered on to SystmOne by the secretaries, the letter highlighted that the patient had suffered seizures due to use or withdrawal from alcohol. Again only if actions for the GP were identified would this have been reviewed, there by the possibility of the GP missing knowledge around substance misuse which might affect future treatment or support.

- The patient had on a number of occasions (3-4) during May-Oct attended practice, with the exception of 1 occasion this was to request a sick note or script nothing more in-depth. Only during 1 consultation was there any indication that the patient had disclosed any upset or disturbance within his personal life. The GP made very minor reference to this, and it was difficult to determine from documentation the level of concern that the patient had disclosed, so would have been difficult for colleagues to have picked up any salient issues in future consultations.

- Recordings from NCH&C rehab team were found to be long and descriptive, included high level of information regarding the patient's partner (perhaps inappropriately recorded on his records?), and did not identify any clear summary of findings or actions taken. It is unclear whether NCH&C clinicians believe that the GP practice accesses and reads all of their documentation or intends them to.

Recommendations for consideration

1. Develop clear lines of communication with NCH&C staff to ensure that where they feel that relevant details have been documented within the shared record that they believe GP/Practice should be party to and that they ensure they alert and where possible summarise actions/concerns for clarity.

2. Due to the nature and impact of Mental health illness and substance abuse upon physical health and variability of risk factors and coping strategies for patients, if other professionals contact the practice to inform that a referral has been made in relation to these areas the GP should be alerted so that any subsequent consultations can be undertaken with this awareness. Safeguarding/Domestic violence concerns highlighted should also be managed in the same way.

3. Where other medical input highlights substance misuse (i.e. reports following admissions) this could impact upon the support or prescribing offered at future practice consultations therefore consider making GP/nursing staff aware.

4. While understanding the limited timeframe of appointments and therefore ability to document consultation details, ensure that GP's make as full a history of any areas of mental upset or likely personal life instability discussed for the information of successive colleagues.

[redacted] - Nurse Member of governing body

12/05/14