NORWICH PRACTICES LIMITED

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Norwich Practices Health Centre

Response to the report written by
Jacqueline Lake
Senior Coroner
NORFOLK

Report Prepared by
Board of Directors at Norwich Practices Health Centre

Introduction

We are collectively the Board of Directors of Norwich Practices Health Centre comprising both senior management personnel and clinicians. The aim of this report is to respond to the concerns raised by Jacqueline Long, Senior Coroner, Norfolk, regarding the events that lead to the death, by suicide, of Solomon James Bealey.

Learning Outcomes and Action Plan

The practice has regarded this tragic death as a significant event and reviewed its policies and procedures.

For the purpose of this report we will concentrate on what happened within this organisation, the lessons learnt and what we have done to prevent this type of incident happening again.

1. The GP, when seeing Soloman for the first time in December 2010, felt slightly uncomfortable that there was a delay in presentation but felt that there were no immediate safeguarding issues.

   Learning Outcome - It is likely that a discussion with a member of the Safeguarding team at this time would have triggered their involvement.

   Action – Reflective discussion with the Designated Nurse for Safeguarding Children. It may have been helpful for the GP to have discussed his concerns with a member of the designated team who could have supported him in securing an earlier appointment with CAMHS. They would have also been able to provide him with professional peer support.

2. On receipt of the letter from CAMHS team, following Soloman's appointment, there was nothing documented on his record by the GP who filed the letter so subsequent clinicians, unless they looked at the scanned document, would have been unaware of the care plan.

   Learning outcome - The letter clearly stated several action points although it is unclear where the responsibility for these lie. We accept that we could have explored this further and agreed clear lines of responsibility with the CAMHS team.

   Action – The clinical team are in the process of developing a template for a Mental Health Care Plan to be integrated onto SystmOne, our hosted clinical IT system. As a result of this review, Mental Health Care Plans already in place have been read-coded. This triggers a patient status alert which is visible under the patient demographic box and on the patient's home screen. Patients that we have identified will have a review of their care plan before 30.11.15 and any concerns will be discussed at our weekly clinical meeting.

3. A further letter from a CAMHS Practitioner was received on 12th April 2011 in which it is stated that he saw Soloman on 19th January 2011 and his mood had greatly improved. Unfortunately, due to illness in his family, Soloman had been unable to attend further appointments after this. The practitioner spoke to Soloman's mother on 22nd March 2011 and she informed him that Soloman's mood had greatly improved and that neither he nor his family felt they needed any further support from CAMHS. We were unaware that Soloman had not attended any appointments after January until we received this letter on 12th April 2011.

   Learning outcome - This letter was filed, no action taken. Although this was seemingly a discharge letter citing a positive outcome we did not instigate any follow up to ensure ongoing support to Solomon or his family. This was possibly a missed opportunity to engage with Solomon and his family and to remind them of the ongoing support and advice available to them from the practice, although this is not routine practice on receipt of a discharge letter.

   Action – For patients identified as a significant concern, discharge notices from the Mental Health team will trigger contact, via telephone, from the practice to the patient to offer an appointment for GP review to discuss ongoing need for support.

4. The nurse who saw Soloman on 1st October 2014 prompted discussion of Soloman as a Patient of Concern at the clinical meeting on 7th October 2014. Following the meeting the GP tried to contact Soloman's mother by telephone but it was the wrong number. Subsequently, a letter was sent by the GP outlining her worries to Soloman's parents. This was not responded to and neither was the subsequent letter of 21st October 2014. Unfortunately, there was no further follow up or discussion.

   Learning outcome – We accept that we should have investigated the wrong telephone number and pursued the lack of response to our letters.

   Action - We have a standing agenda item 'Patients of Concern' at our weekly clinical meeting. With immediate effect, we have agreed to have a 'Patients of Significant Concern' register. Patients will be added as agreed at the clinical meeting and the register will be reviewed weekly. Patients will only be removed from the list if the level of concern has lessened or resolved.

Your report and our subsequent review has been discussed with the whole team at our clinical meeting on 3rd November 2015. The above learning outcomes and action plan has been shared and agreed.

Recommendations to reduce risk of future deaths

- Improvement in communications between Mental Health teams and practices.
- Any suicide attempt made by a child under 16years will trigger an automatic referral to the Safeguarding Team.
- Multi-agency involvement at the earliest opportunity, in this case, the GP, Designated Safeguarding team, CAMHS, Sprowston High School, Parents.
- Clear lines of responsibility where an action plan is in place, with time frames where indicated.
- Indication on patient records that a Mental Health Care Plan is in place.
- Offer of continuing support to patients of significant concern who have been discharged from the Mental Health Care team.
- This process will be reviewed in 6 months' time (May 2016)

It would be useful if the responses from the other agencies involved could be shared with Norwich Practices Health Centre. In addition, if there are any further recommendations as a consequence of this tragic case then we would be very happy to implement them.

Should you have any queries relating to this case or my response to your report, please do not hesitate to contact us.