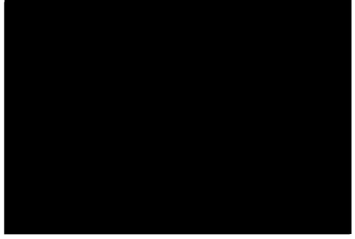
# ***The Seaton & Colyton Medical Practice***



**148 Harepath Road**
**Seaton**
**Devon EX12 2DU**
**Tel: 01297 20877**
**Fax: 01297 23031**

Mr John G Tomalin
HM Deputy Coroner
Exeter and Greater Devon Coroners's Office
Room 226 Devon County Hall
Topsham Road
Exeter
Devon EX2 4QD

Our Ref:

20 July 2016

Dear Mr Tomalin

Re: **Mrs Jessica Mary BIRKHEAD (D.O.B. 07.06.1985)** ***deceased 28 July 2015***

I am writing in response to your letter addressed to dated 02 June 2016. I wrote to you on 08 June 2016 and I note your letter dated 07 July 2016 in which you state that you are happy for my response to the Regulation 28 Report made into the death of Jessica Birkhead, which I have prepared on behalf of who has retired, and the current partners at the Practice.

I take note of the contents of the Regulation 28 Report and in particular your concerns as stated in note five of the report.

Jessica first moved into the East Devon area in August 2006 when she was registered at the Honiton Surgery. At the time she had moved from a specialist unit in Minehead to live in a specialist care home in Honiton. She had a case manager and care worker. In addition, she was referred to a clinical psychologist who worked with her over the following year. She saw her GP regularly and following completion of the work with the clinical psychologist was referred to the East Devon Learning Disability Team in November 2007. She continued to have regular health checks with her GP while she lived in supported accommodation.

In December 2012 she was registered at the Devon Square Surgery in Newton Abbott. She was referred to a consultant psychiatrist in March 2013 by her GP.

She then moved to Colyford to live with her husband, baby and mother-in-law. At this time she registered with the Seaton & Colyton Medical Practice. She was reviewed by Consultant Psychiatrist with the Learning Disability Partnership on 05 April 2013 who set out a clear plan for her care. This was shared with her social worker and clinical psychologist. She was reviewed again by in July 2013. Following this she had a further clinical psychology assessment between June and September 2013. She was reviewed again by Consultant Psychiatrist with the Learning Disability Partnership, in October 2013 with the plan to keep her under regular review. There followed further assessments in March 2014 and June 2014.

20 July 2016

Re: **Mrs Jessica Mary BIRKHEAD (D.O.B. 07.06.1985)** ***deceased 28 July 2015***
**NHS No. 474 405 1022**

Subsequent to this, [redacted] and [redacted] suggested that Jessica might be referred for cognitive behavioural therapy and referred her to the Depression and Anxiety Service. She was reviewed again by [redacted] in October 2014. She continued to have regular contact with her GP and had a full learning disability health assessment in November 2014 coordinated by her social worker. She also had further appointments with the Depression and Anxiety Service. [redacted] saw her again on 18 March 2015 when she was accompanied by her occupational therapist from the Community Learning Disability Team. She remained under the care of the Learning Disability Team and consultant psychiatrist. She also remained under the care of the Depression and Anxiety Service having been rereferred to them in April 2015.

Jessica sadly died on 28 July 2015 having taken an overdose. There is no reference in her primary care records that she expressed to her GP any thoughts of deliberate self-harm. I take note with regards to the "Matters of Concern" raised under Regulation 28. However, it is my opinion that Jessica was under the care of a consultant psychiatrist specialising in learning disabilities, the Devon Learning Disability Team and also the Depression and Anxiety Service, as had previously been arranged by two consultant psychiatrists. It is not, therefore, my view that the support services were not equipped to deal with someone of Jessica's intellectual disabilities.

The Seaton & Colyton Medical Practice held an informal Significant Event Audit Meeting following Jessica's death, following which [redacted] provided a report to the Coroner as requested. Following receipt of the Record of Inquest and taking particular regard to the Regulation 28: Report to Prevent Future Deaths, the practice will hold a formal Significant Event Audit Meeting in which we will discuss Jessica's case and consider appropriate pathways for others in the future in a similar situation to Jessica to take into account any learning difficulties and associated medical problems.

I trust that this reply is satisfactory and we will forward the results of our Significant Event Audit when it has taken place.

Yours sincerely

[signature]

[redacted]

RECEIVED 2 2 JUL 2016