Browning Street Surgery,
10 Browning Street,
Stafford
ST16 3AT

Mrs M J Jones
HM Assistant Coroner,
Coroner's Office,
No1 Staffordshire Place,
Stafford
ST16 2LP

13.3.2014

Response to Prevent Future Deaths Report: Miss Pauline Meredith

Dear Mrs Jones,

Thank you for sending the Prevent Future Deaths Report dated 10th January. The practice has taken your concerns very seriously and I am writing this response on behalf of the practice. Since the Coroner's Inquest on 9th January the partners and practice manager have held a meeting in which we discussed the report as well as the events leading up to Miss Meredith's death and whether any more could have been done to prevent her death and possible future deaths.

As you have acknowledged in your report, Miss Meredith was a chaotic and vulnerable adult who had a long history of behavioural and mental health problems. She had a number of emotional traumas and life events in the past which led to her coping with stress with angry outbursts, alcohol binges, self-harm and overdoses. She also suffered with chronic pain from a compressed fracture of lumbar vertebra as well as abdominal pains from adhesions following her appendix abscess and subsequent operations. At the time of her death she had additional painful orthopaedic problems - she was being followed up by orthopaedic surgeons regarding a fracture of her metatarsal in her foot and a fracture of her elbow. She had brief episodes of support from mental health and alcohol services through the years but her engagement with this was usually short-lived. The practice has responded to a significant challenge in attending to her multiple physical and psychological health needs over the last 15 years. Miss Meredith died from a self-administered but accidental overdose of prescription drugs.

In considering the context of Miss Meredith's care, I would wish to point out that I have significant experience in mental health. I was Clinical Champion for Mental Health and Learning Disability for South Staffordshire PCT from 2008 to 2010 until funding was withdrawn for all Clinical Champion roles. As a GP with Special Interest in Addictions, I have additional expertise in managing addiction, and as a Trainer for the Royal College of General Practitioners for the 'Certificate in Management of Substance Misuse in General Practice' as well as 'Managing Alcohol Dependence in Primary Care' course. I have expertise in managing opiate dependency having treated addiction patients in General Practice for over 15 years. I have delivered talks and presentations to health care commissioners, consultants, GPs as well as trainee GPs on substance misuse and mental health. I have also kept my skills updated by attending regular conferences over the past 15 years on Substance Misuse, Alcohol Misuse, as well as conferences on 'Addiction to Prescribed and Over-the-Counter Medication'.
You have raised specific concerns in the Prevent Future Deaths Report and I will address each of these.

1. Amount of medication prescribed and formal medication review
You have expressed concern about the amount of medication prescribed over the years and the lack of a formal medication review process.

Before her death, Miss Meredith was prescribed a weekly prescription for 9 items (including Morphine Sulphate Tablets (Slow Release) 10mg, lorazepam and tramadol) and a monthly prescription for an additional 7 items.

I would wish to reassure you that there is indeed a formal medication review process used at the practice. The medication review system is computer based. The computer automatically initiates a demand for review of medication for each patient who has repeat medications. This is usually annually but can occur more frequently depending on the monitoring requirements stipulated by the prescribing doctor. The computer also places limits on the number of repeats that can be issued without re-authorisation of the repeat medication by a doctor. The review of repeat medication is usually based on clinical information contained in annual health checks or from consultations at the practice or from a dedicated review of repeat medication with the patient.

The Medication Review would authorise medication for the next 12 months for straight forward patients on straight forward medication. Not only were these automatic medication review checks in place for Miss Meredith but additional, special arrangements were put in place for Miss Meredith, to ensure that additional monitoring of her prescribing occurred. The special monitoring was thought necessary since 2000 because Miss Meredith had a history of deliberate overdose. Therefore the practice had arranged it so that Miss Meredith was on prescriptions written every 7 days instead of every month, in order to limit her access to medication, as well as weekly appointments with a doctor to check on her mental state and provide additional support. She was not able to request repeat prescriptions without seeing a GP or at least contacting the practice if she could not attend an appointment. She had to see a doctor in order to obtain a prescription. Hence her medication was controlled by the frequent appointments at the surgery and this allowed for careful monitoring of the medications prescribed.

The most recent documented medication review prior to Miss Meredith's death on 30th August 2013 occurred on 24th June 2013. This involved a discussion with the patient and myself (the prescribing GP). In addition, in the 8 months from January 2013, Pauline had received 32 face to face consultations, 9 telephone consultations and 1 home visit (related to diarrhoea). She had seen other GPs 8 times including 3 other partners and the Nurse Practitioner. Each of these frequent consultations meant that the consulting GP could discuss medication and check on her well-being.

Over her many consultations, I have discussed with her a number of safety aspects of her medication, including: 1) the addictive nature of benzodiazepines, 2) the use of propranolol in asthma, 3) use of zopiclone at a level outside the licensed dose 4) the potential effects of binging alcohol on her seizures as well as on her medication. One such consultation occurred on 11/02/2013 when unusually for Miss Meredith, she had overused her lorazepam. I advised her that this was unacceptable due to the addictive nature of this drug and the risks she was taking by not being compliant with her prescribed dosage. The clinical records show that Miss Meredith was being seen every week and her medication was not simply handed over without a discussion about the risks and benefits. She was fully aware of these risks and the benefits of her medications. For example, I have attached a copy of the practice leaflet concerning benzodiazepines that was given to Miss Meredith on 1/12/2008.

With regard to the suggestion that Miss Meredith had stockpiled her medication, I have no record from the family or police as to the names or the quantity of this medication that was found at her

flat after her death. A system of medication review would not necessarily pick up whether a patient would be stockpiling medication. Miss Meredith would usually come to an appointment with a list of medication that she was running out of. This would usually be the same medication prescribed weekly and this would imply that she required the medicine and that she was taking it as prescribed. The practice would rely on the patient to provide accurate information about their use of medications.

I hope that I can reassure you that Miss Meredith had very careful monitoring of her medication, including regular medication reviews, given the special weekly and monthly restrictions put in place on repeat prescribing for her. In addition, her frequent attendances at the practice provided additional opportunities for her medication to be reviewed by a doctor. Furthermore, there were frequent and frank discussions with her about the risks of her medications and she was fully aware of the risks and potential side effects.

2. Addition of morphine, given high dose of pain killers and alcohol dependence:

Miss Meredith had required long-term pain-relief since 2002 following her compression fracture and fractured ankles when she jumped from her first floor window following a fire. She also had long-standing problems with abdominal pain from her appendix abscess and subsequent operations. At a consultation on 25th February 2013, she asked for additional pain relief.

She had already been referred to and seen by the General Surgeons (9/1/2013) regarding her abdominal pain from her laparotomy operation site. They had referred her to the pain clinic at Stafford DGH where she was assessed by the Consultant Anaesthetist [redacted] (22/1/2013) who had recommended injections into her scar. This was carried out as a day case on the 9/5/2013. There were no further recommendations made regarding her analgesia at either appointment. She attended Orthopaedic Out-patients 6 times in 2013 with the pains from her foot which was found on MRI to be a non-healing fracture of her metatarsal. She was maintained in a plaster slipper from 15/1/2013 throughout this time to alleviate pain. Pauline had continued to complain of severe pains from her foot, elbow and both knees. Her suffering from pain is documented in the GP notes as well as the hospital correspondence. Other interventions apart from medications were tried to help with her pain control. She had both knees and her elbow injected during 2013 in order to try and ease her pain. She was also referred to community physiotherapy on 14th May 2013.

In response to her request for additional analgesia in February 2013, options were limited. For pain relief, she was already taking tramadol 50mg 2 tablets four times daily (maximum dose) plus paracetamol 500mg 2 tablets four times daily (maximum dose) and diclofenac 50mg three times daily (maximal usual dose). I was reluctant to prescribe co-codamol or codeine or dihydrocodeine. These had previously been prescribed with little effect on her pain. She was already on a strong anti-inflammatory painkiller (diclofenac) and so there was little value in changing to an alternative anti-inflammatory. As Miss Meredith's pain appeared significant, I decided to prescribe MST (slow release morphine sulphate tablets) 1 tablet twice daily at the lowest dose possible, 10mg. The treatment plan initially was to prescribe this for one week and then review whilst she regained control of her pain. Miss Meredith was instructed to use the morphine twice daily and to use tramadol for any break through pain.

After one week she had said that the MST had helped with her pain and therefore Miss Meredith asked to continue on MST 10mg twice daily. Miss Meredith continued on a weekly prescription for MST from February until her death in August 2013.She was asked whether she found the MST helpful at later dates when her pain-symptoms were discussed and importantly also after the

discussion with her mother on 15th July 2013. The continuation in prescription occurred because she continued to state that MST helped her pain. Miss Meredith throughout this time had genuine physical reasons for her pain, given her history of fractures and abdominal wall pain. I can provide letters from the orthopaedic surgeons that document the fractured bone in her foot and possible fracture in her elbow and from the pain clinic regarding her abdominal wall pains, if necessary. These provide evidence documenting the severity of Miss Meredith's pain.

In considering whether MST was appropriate, I took into account that her drinking had become less frequent in the 10 months before her death. Rather than being dependent on alcohol, as she had been previously, she was having frequent drink free days and drinking much less during a session. She was well aware of my concerns about her binge drinking she had a history of excessive drinking leading to black-outs, falls and amnesia. Her elbow injury had happened in November 2012 following a fall when drunk. I considered her alcohol intake when considering the appropriate analgesia to prescribe but was reassured by the fact that she had controlled her alcohol intake much better than previously. In January she stated that she was still binge drinking but had reduced the amount she had been consuming. In a consultation with Dr Knight at the Surgery on 15th May she described her alcohol intake as "0 units a week".

In summary, morphine sulphate was prescribed as there were little options for her pain control and she was already on tramadol, paracetamol and diclofenac. The morphine was planned to work in combination with her other analgesic medication. Previously, other opiates such as codeine and dihydrocodeine had been ineffective. The MST was the lowest slow release formulation and was issued on a weekly prescription, therefore regular review was in place. The patient continued to state that it did help with her pain control. She had also curtailed and reduced her drinking considerably and was not dependent on alcohol, and she knew about the risks of binge drinking with her medication. It is important to also consider that, after 4-8 weeks on morphine, she would have developed a tolerance to the morphine by regular dosing, which would have reduced any side-effects and also reduced the risk of any potential toxic effects such as respiratory depression.

3. Perceived reluctance to listen to family's concerns:
It is regretful that the family perceive that their concerns were not being listened to. I had no direct contact with Pauline's sisters who are not patients at the practice. At consultations over the years when [redacted] had attended with her daughter, she had raised concerns about her daughter's reliance on medication which I had discussed with Miss Meredith but since 2010 Miss Meredith had been mentally and emotionally much more stable with no overdose attempts.

I spoke with [redacted], Pauline's mother, on 15th July 2013 during a telephone consultation and took on board the comments she made regarding her daughter's paranoid thoughts about her neighbours. This was the first that I knew that Pauline was arming herself at night with knives and roping up her doors when she was in her flat at night. [redacted] also expressed her concern that Pauline's paranoia had started following the addition of MST. For reasons of confidentiality it was inappropriate to provide any specific information about Miss Meredith's condition or medication directly to her mother without Pauline's consent but I certainly listened to these concerns.

I documented the concerns:
Tel Consultation [redacted] 15th JULY 2013 at 08.55
"Concern over daughter…. Who is anxious and agitated
Paranoid re neighbours
Putting herself and others at risk
Borderline paranoid schiphrenic
Seeing daughter later… likely to involve CMHT"

I discussed this with Miss Meredith's later that morning in a consultation that took 22 minutes. I planned to refer Miss Meredith to the Community Psychiatric Nurse (CPN) via the Mental Health Team based on what I had been told by her mother as well as her increasingly anxious and paranoid thoughts. Unfortunately and regretfully this was not done that day and so was delayed as I was working away from Stafford most of that week. In fact despite comments in the records for Pauline's next consultation on 22nd July, "*awaiting CPNs*", it was not until the 5th August that I realised that the referral had not in fact been made. This was then faxed that day to the Community Mental Health Team.

I wish to reassure the family that I did take seriously and actively followed-up [redacted] concern by discussing this with her daughter when I saw her later on the same day 15/7/2013 and I continued to assess and consider these concerns during her subsequent consultations. There is no other documented approach by any family member to the practice, expressing any other concerns.

With regard to [redacted] concern about the paranoia being related to the morphine, I did not consider this to be likely. Miss Meredith's thoughts seem to be a localised paranoia as otherwise her mental state seemed appropriate, according to the information that I had from Miss Meredith and her family. My impression was that it would be very unusual for Morphine to trigger paranoia and her paranoid thoughts were more likely to be a response to stressful situations.
Morphine is not usually associated with paranoia or delusions, although can be associated with hallucinations, confusion and agitation. I addition, I considered that Miss Meredith's paranoid thoughts were similar to her previous episodes when she reported paranoid feelings between 2003 and 2006. At that time she had thought that she was being followed by special branch or inspectors from the benefits agency. These thoughts and feelings persisted for several years but were again well-contained and settled in due course. They did not coincide with any morphine prescribing.

Several times during 2013, I challenged her paranoid way of thinking and she did accept that her paranoid feelings could have been false thoughts rather than reality. Miss Meredith reported that her neighbours had apparently been arrested for growing cannabis on the 14th January 2013. Miss Meredith continued to experience stress, related to a family situation as well as to a chest infection and then diarrhoea after visiting her brother in Cardiff. My clinical impression was that she did not have a psychotic illness and the stress was causing increased paranoid thoughts unrelated to morphine prescribing but related to the many other causes of stress.

In reflecting on this point with [redacted] Consultant Psychiatrist and Clinical Director South Staffordshire and Shropshire Healthcare NHS Foundation Trust, he agreed that it would be unlikely that the morphine would cause such focussed paranoid thoughts without causing a more generalised confusion.

I am very sorry that the family feel I had not taken their concerns on board. The family approached the practice with concerns only once and these concerns were certainly discussed with Miss Meredith on the day that they had been raised by her mother. I continued to consider and assess [redacted] concerns in my subsequent interactions with Miss Meredith. Miss Meredith herself felt that the morphine was helpful rather than causing problems. My assessment was that the paranoid thoughts were not related to morphine but to Miss Meredith's stress.

Looking back at events, it would have been useful with Miss Meredith's consent to have had the opportunity to feed back to her mother either directly or in a joint consultation with family members.

4. The lack of team meetings to discuss challenging patients:
It is likely that I would have discussed Pauline and her anxiety and paranoid thinking with my General Practice colleagues in an informal way, as this often occurs in the course of General Practice when challenging problems are posed by patients, but I cannot recollect when this may have occurred. Informal discussions are not recorded in the notes.

Regular clinical meetings occur at the practice in order to discuss clinical issues and this often involves patients with complex clinical and psychological problems. However, in the period prior to her death, I did not consider there was a need to discuss Miss Meredith's care at a meeting, as she was going through a period of relative stability. She was still receiving a lot of support and supervision, being seen by a doctor every week over a prolonged period of time. Her overdoses and self-harm had curtailed significantly since 2010.

However, having considered these events as a practice, the practice will endeavour in the future to identify complex patients who might benefit from discussion at clinical meetings. These triggers could include concerns expressed by doctors, relatives, neighbours and other organisations such as police and housing.

5. Approach to involving community mental health services:
The report raises a concern that there could have been a more timely approach to involving community health services.

Browning Street Surgery has established a reputation locally for supporting patients who are vulnerable and with complex mental health needs. Over the last 18 years as a GP partner and especially in my role as Clinical Champion for Mental Health I have been an advocate for patients with mental illness and have been constructively critical of failings in mental health services. I have also been involved in introducing the current primary care mental health service into South Staffordshire. I have lectured and given presentations on mental health services and treatments at GP and Commissioners at conferences in Staffordshire and the West Midlands.

The partners in the practice have discussed the circumstances around Miss Meredith's death and have considered whether involvement of mental health services any sooner would actually have made any difference to the eventual outcome.

Miss Meredith was referred to specialist mental health services on 5th August, 3 weeks before she inadvertently took an overdose. A letter from the Community Mental Health Team was sent to the patient (and copied to the practice) dated 6th August 2013, inviting the patient to contact them to arrange an appointment. This was received at the practice on 13th August.

Miss Meredith was last seen by any form of mental health service following an impulsive overdose in November 2010. She was reviewed by liaison psychiatry whilst in Stafford DGH following her overdose. There is a letter from psychiatry from earlier that year, dated 26th March 2010 stating that Miss Meredith had not attended 2 appointments with [redacted] Consultant Psychiatrist, which resulted in her being discharged.

Other mental health contacts are documented below:
She had been referred in 2003 to [redacted] Consultant Psychiatrist and also to the Community Psychiatric Nurse with paranoid ideas. At this time her levels of stress had provoked paranoid thoughts that she was being followed. These thoughts were well contained and did not interfere with her normal functioning. They continued for several years last being mentioned in 2006. She initially thought this was special branch and related to her Northern Irish connections but later was

concerned that it was inspectors from the Benefits Agency checking up on her. Her paranoid thinking diminished in due course.
She was referred again in 2005 to the Community Mental Health team and again she did not attend any appointments.

Since then she had contact with mental health services on the following dates:
20.11.2009; Liaison Psychiatry at Stafford DGH following overdose, referred to Community Mental Health Team (CMHT) and also to Crisis Service. Miss Meredith failed to engage with either service.
22.12.2009; Liaison Psychiatry at Stafford DGH following overdose. She was referred to [redacted] Consultant Psychiatrist. She was offered two appointments but failed to keep either and so was discharged from mental health services.
5.5.2010; She was referred to ADSiS (Stafford based alcohol support service) where Miss Meredith attended several appointments with the support worker at the surgery.
12.5.2010; She attended Stafford Accident and Emergency following an overdose and with superficial lacerations to wrist. The following day, she re-attended Stafford Accident and Emergency with further lacerations. She assessed by the Liaison Psychiatry Team and was referred to the Crisis Team but failed to engage.
25.7.2010; Miss Meredith cut her wrists and was admitted via at Stafford Accident and Emergency with a significant laceration to her wrist requiring reconstructive tendon surgery under the Orthopaedic Surgeons. No mental health input was documented.
5.11.2010; Miss Meredith took an overdose of paracetamol requiring admission and treatment. She was assessed by the Liaison Psychiatry Team but no further follow up was arranged with Mental Health Services.

Paranoid Thoughts:
I have studied the medical notes regarding Miss Meredith's thoughts and concerns about her neighbours and this is shown below:
12th November 2012, Miss Meredith had stated that she had been up all night as her neighbours were making too much noise all night.
On 14th January 2013, she stated that her neighbour had been arrested for growing cannabis. There are then no further documented concerns about her neighbours until a consultation on 25th March. Her consultations were preoccupied with other stresses and also a severe bout of infective diarrhoea.
On 22nd April and 4th May, Miss Meredith expressed further stress with her neighbours and on the later date I suggested a referral to the Community Mental Health Team. This she declined.
The next recorded comment about her neighbours is the 3rd June. This was the night she claimed to have been beaten up by "druggies" and then arrested by the police. She attended Stafford Accident and Emergency on the 6th June with injuries that she claimed had arisen from these events 3 days earlier.
The following week on the 10th June, Miss Meredith said that she felt threatened by her neighbour. It was not until 1st July that Miss Meredith expressed more extreme thoughts to me that she was being "bugged or followed". Her thoughts seemed contained to her flat and neighbours with no other disturbed thinking. The consultation was described in the medical notes as a *"frank discussion about concerns if paranoia started being overwhelming. Still claims that she feels relaxed at home".* I rang her the following day and she had slept well and said that she was more settled.
The following week on 8th July, Miss Meredith was agitated and stressed after rows with her mother. Again I suggested a referral to mental health services either the Community Mental Health Team (specialist mental health service) or Emotional Wellbeing in Stafford and Surrounds (primary care mental health service).

Miss Meredith was reluctant to be referred to the Community Mental Health Team and the subject of referral was broached with her on several occasions 7/5/2013, 1/7/2013, 8/7/2013 and 15/7/2013. She finally consented to a referral on 15th July. I was sceptical as to whether she would engage or also how useful that additional support would be.
Inadvertently although I thought this referral had been made on 15th July, it was in fact overlooked that week as I was working elsewhere. I referred Miss Meredith to the Community Mental Health Team on 5/8/2013 causing a delay of 2 weeks. I have copies of two letters sent by the CMHT to her asking her to make contact by ringing the Team in order to make an appointment. These are dated 6th August and 23rd August.

I saw Pauline on 5th August and then 16th August before I was due on leave for two weeks. Her mental state appeared anxious but not psychotic. She was agitated and continued to have paranoid thoughts focussed on her neighbours. She appeared to be functioning and was still seeing her mother regularly. Even at the inquest the family said she had been in good spirits and "upbeat" the evening before her death.

During my absence, Pauline was also seen by North Staffs A/E and admitted overnight with melaena to University Hospital North Staffordshire (20th -21st August 2013). She also attended Stafford A/E on 27th August with her foot pain. She had already had a review by orthopaedic consultant on 2nd August. There is no comment about the deceased's mental state in any correspondence.
I was not aware of the number of frequent police contacts until after her death, when a letter dated 27th August 2013 arrived from the Neighbourhood Police Team.

Summary: Miss Meredith had been much more stable since a difficult period in 2009-2010 which was associated with overdoses and self-harm during which she had never engaged with mental health support. In 2013, she was dealing with significant levels of family stress and had developed paranoid ideas about her neighbours. Otherwise her mental state although anxious was certainly not psychotic and she continued to function relatively normally. Miss Meredith refused to accept a referral to mental health services on at least 3 times between May and July 2013 when I suggested it. There was no time when she was so disturbed that she could have been sectioned under the Mental Health Act. She maintained capacity and so had to consent to any referral being made. It was not until 15th July 2013, using the information obtained from the telephone consultation with her mother, that I was able to persuade Pauline to accept additional mental health support. Unfortunately, the referral was inadvertently delayed, eventually being faxed on 5th August and the Community Mental Health Team sent her an initial contact letter dated 6th August 2013 followed by a second letter on 23rd August.

Actions to be taken
As a practice, we have carefully discussed these events to determine personal learning or any need for changes to practice processes. The practice has considered three strategies following the Coroner's Inquest;

1) We have formally instigated a programme of regular practice meetings which will look at all deaths in the under 50's. In the past this has been adhoc but now the process will be more formal. Deaths in young people are infrequent but also extremely significant and the practice wishes to ensure all that can be done is done to prevent these. A protocol for this will be written and agreed within the next month. The first meeting will take place in the next 2 months and will continue thereafter.

2) The practice will endeavour in the future to identify complex patients who might benefit from discussion at clinical meetings. The practice is currently considering how to select patients for these

meetings in a more structured way. These triggers could include concerns expressed by doctors, relatives, neighbours and other organisations such as police and housing. The practice would hope to define the criteria for identifying these patients, draw up a protocol for these meetings and hold its first meeting within the next 2 months.

3) Miss Meredith had seen 3 other doctors and the nurse practitioner in previous 8 months before her death. Having reflected on this case, I recognise that it can often be useful to have another clinician with a fresh pair of eyes looking at patients with chronic problems. The practice will consider whether there are circumstances where the medication reviews are best carried out by another doctor who is not so involved with the case. This would be actioned by the regular doctor asking for a medication review by a colleague who was not involved in management of the case. This is to be initiated from now.

Personally, I will continue to strive to complete all referrals at the time of the consultation rather than risk delay in a referral being made.

Additional Comments and Summary
You have raised 5 concerns which have been addressed in this response:

1) The amount of medication prescribed as related to multiple physical and mental health problems.
Medication was prescribed in a controlled way with weekly prescriptions following weekly consultations. Routine formal medication reviews of her medication did take place and the final formal review before the date of her death was carried out on 24/6/2013. In addition, Miss Meredith had frequent consultations and each consultation afforded the opportunity to review medication. The patient was aware of the risks if her medication was misused and there is documented evidence of this. The practice will consider whether complex medication reviews would be better carried out by a doctor who is not directly involved with the patient.

2) The addition of morphine given existing pain relief medications and history of alcohol
Morphine was instigated following a lack of response to a combination of strong pain-killers (tramadol/paracetamol) and anti-inflammatory tablets (diclofenac), to treat conditions that were causing significant pain. The morphine was intended to work in combination with her other medications. Miss Meredith had improved her alcohol intake considerably.
Although initially started as short term, Miss Meredith claimed to find benefit from morphine and so it was continued. It was the lowest dose of slow-release morphine and was prescribed in weekly prescriptions with usually a weekly consultation to monitor progress.

3) The family perceived a reluctance to listen to their concerns
[redacted] was able to discuss her concerns with me. She discussed her concerns about morphine and paranoid thoughts during a telephone consultation on 15th July. The information she passed on about her daughter was important to me and I very much considered this valuable and helped to inform me as to the circumstances at home. Her concerns were in fact discussed with Miss Meredith on the same day that her mother had expressed them. The information she passed on about her daughter was important and helped me persuade Pauline that she needed help and to finally agree to a referral to the Community Mental Health Team.

4) Team meetings to discuss challenging patients
There are regular team meetings held at the practice. These discuss many issues including significant events and care planning of frequent attenders at A/E. In the future, the practice will endeavour to identify patients with additional complex needs for specific discussion at practice meetings.

5) The lack of timely proactive approach to mental health services
Miss Meredith had paranoid thoughts in the past but these had settled. She had been reluctant to engage with mental health services previously and refused to consent to a referral until 15th July 2013. She was assessed as having capacity to make this decision and admission under the Mental Health Act was not appropriate. When a referral was made for additional support on 5th August, Pauline should have received a letter from the Community Mental Health Team dated 6th August within a few days. She should have then received a second invitation letter dated 23rd August. Both letters asked her to contact the mental health team's telephone number to arrange an appointment. This is the appropriate referral process for the Community Mental Health Team within the South Staffordshire and Shropshire Healthcare NHS Foundation Trust.

The practice aims to maximise the health and wellbeing of our patients. We endeavour to provide excellent care for our many vulnerable patients with complex mental health needs. Miss Meredith died after inadvertently overdosing herself with prescribed medication. It must be acknowledged that she had very complex medical and psychological complaints and made informed decisions about the risks of her medications and about recommendations made to her to accept a mental health referral. However, the practice is keen to implement change in order to improve our service to patients and will introduce the steps laid out in this response.

I hope this response addresses and reassures your concerns about my support for Miss Meredith as well as the service provision at Browning Street Surgery.

Yours sincerely,