REGULATION 28 REPORT TO PREVENT FUTURE DEATHS

THIS REPORT IS BEING SENT TO: [redacted] and Partners, Stockport Medical Group, Edgeley Medical Practice, 1-3 Avondale Road, Edgeley, Stockport SK3 9NX.

CORONER

I am Chris Morris, Area Coroner for Manchester South.

CORONER'S LEGAL POWERS

I make this report under paragraph 7, Schedule 5, of the Coroners and Justice Act 2009 and regulations 28 and 29 of the Coroners (Investigations) Regulations 2013.
http://www.legislation.gov.uk/ukpga/2009/25/schedule/5/paragraph/7
http://www.legislation.gov.uk/uksi/2013/1629/part/7/made

INVESTIGATION and INQUEST

On 2nd March 2018, Rachel Galloway, Assistant Coroner, opened an inquest into the death of Andrew Arthur Dickson who died on 15th February 2018 aged 30 years. The investigation concluded at the end of the inquest which I heard on 13th August 2018.

At the end of the inquest, I determined that Mr Dickson sustained fatal injuries having jumped from a viaduct to his death. I recorded a conclusion of Suicide.

CIRCUMASTANCES OF THE DEATH

Mr Dickson was a relatively infrequent attender at his GP surgery, and had not until shortly before his death sought medical attention as a result of any concerns relating to his mental health. In the final week of his life however, those closest to Mr Dickson became profoundly concerned about him.

On 12th February 2018, Mr Dickson's mother persuaded him to consult with a GP and indeed sought to arrange an appointment on his behalf. The practice computer system records the rationale for her request (made by telephone to a receptionist) for an appointment as being "*having suicidal thoughts for few days*". The evidence before the court was that this message resulted in the generation of an alert note on screen which the telephone triage doctor would see.

Following telephone triage, an appointment with a GP took place later that day during which both Mr Dickson and his mother were present. The entry in Mr Dickson's clinical notes relating to that consultation makes no reference to any discussion about suicidal thoughts, or indeed reference to the communication with the receptionist earlier that day.

As a result of the consultation, the GP considered Mr Dickson appeared to be suffering from an anxiety disorder, which may have been exacerbated by drug use. Mr Dickson was signposted to the community drug team, encouraged him to see a counsellor and prescribed a course of sertraline, with accompanying advice as to the intended benefits and potential side effects of that medication. The GP also arranged for blood tests to be taken and put a plan in place to review Mr Dickson in a months' time, once those results were available and the sertraline had sufficient opportunity to be effective.

CORONER'S CONCERNS

During the course of the inquest the evidence revealed matters giving rise to concern. In my opinion there is a risk that future deaths will occur unless action is taken. In the circumstances it is my statutory duty to report to you.

The **MATTERS OF CONCERN** are as follows. –

Notwithstanding the obvious significance of the information provided to the practice by telephone on 12th February 2018 when an appointment with a GP was sought on the basis that Mr Dickson had been having suicidal thoughts, the evidence before the court was that whilst this information is made available to the telephone triage doctor by way of alert note, the same text is not incorporated in to the screen which a doctor subsequently undertaking a face-to-face appointment sees.

This raises the following matters of concern:-

1. The safety of the computer system as currently operated appears to be prefaced on the telephone triage doctor being the same clinician who sees the patient at a subsequent face-to-face consultation, and remembering the content of the alert note despite having had to undertake a multitude of other tasks in the meantime;

2. In the alternative, the onus is likely to fall on the patient (or his / her representative or carer) to repeat information in the course of the consultation which may already be in the practice's knowledge as a result of an earlier telephone call to an administrative member of staff, and which the patient (carer or representative) is likely to assume is already in the doctor's possession;

3. The system as currently operated appears likely to create additional risk in a group practice (in circumstances where the telephone triage doctor may be based in a different location from the doctor undertaking a subsequent consultation), and where patients may be vulnerable or reluctant to engage with a doctor for any reason.

ACTION SHOULD BE TAKEN

In my opinion action should be taken to prevent future deaths and I believe you and your organisation have the power to take such action.

YOUR RESPONSE

You are under a duty to respond to this report within 56 days of the date of this report, namely by 29th October 2018. I, the coroner, may extend the period.

Your response must contain details of action taken or proposed to be taken, setting out the timetable for action. Otherwise you must explain why no action is proposed

COPIES and PUBLICATION

I have sent a copy of my report to the Chief Coroner and to [redacted] on behalf of Mr Dickson's family. I have also sent a copy to [redacted] of DAC Beachcroft LLP, solicitors to the Medical Defence Union.

I have sent a copy of my report to Stockport Clinical Commissioning Group and the Care Quality Commission, who may find it useful or of interest.

I am also under a duty to send the Chief Coroner a copy of your response.

The Chief Coroner may publish either or both in a complete or redacted or summary form. He may send a copy of this report to any person who he believes may find it useful or of interest. You may make representations to me, the coroner, at the time of your response, about the release or the publication of your response by the Chief Coroner.

Dated: 3rd September 2018

Signature:

Chris Morris HM Area Coroner, Manchester South