National Medical Director &
Interim Chief Executive, NHSI
Skipton House
80 London Road
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SE1 6LH

Ms Alison Mutch
Senior Coroner for Area of
Greater Manchester South
Coroner's Court,
1 Mount Tabor Street,
Stockport
SK1 3AG

17th November 2021

[redacted]

Dear Ms Alison Mutch,

Re: Regulation 28 Report to Prevent Future Deaths – Bituin Pimlott
22nd February 2021

Thank you for your Regulation 28 Report dated 13th August 2021 concerning the death of Mrs Bituin Pimlott on 22nd February 2021. Firstly, I would like to express my deep condolences to Mrs Pimlott's family.

I note that the recent inquest earlier this year concluded that the medical cause of Mrs Pimlott's death was: 1a hanging.

Following the conclusion of the inquest you have raised concerns in your Regulation 28 Report to NHS England with the following matters of concern:

1. The inquest heard evidence that Mrs Pimlott had been struggling with her mental health in the weeks preceding her death and had contacted her GP on a number of occasions with anxiety and depression. She was prescribed medication but expressed concerns about the impact of the medication. Telephone consultations rather than face to face appointments continued to be used with her due to the pandemic. Pre-covid it was accepted she would have been seen face to face which would have allowed a more comprehensive assessment of her mental health and her reluctance to use medication.
2. Her GP practice did not refer her to the crisis team, and it was unclear what guidance the practice had for their GPs about when they should refer directly to the crisis team.

I note the concerns that you have raised and I can confirm that telephone consultations have been in use in general practice for many decades to help patients access medical advice and care quickly and conveniently. Where studies have been

conducted, telephone triage has been shown to be safe. Further telephone consultations are part of general practice training schemes.

The coronavirus (COVID-19) pandemic has brought about an unprecedented acceleration in the adoption of delivering NHS services remotely, and standard operating procedures (SOPs) were produced to ensure general practice is able to operate safely in this context. The SOP which was last published (now retired) which is relevant in this matter is attached for reference. I can confirm that SOPs were iterated throughout the pandemic to meet changing needs and requirements since first publication. This SOP was first published in March 2020.

The procedures within the relevant SOP make it clear that general practices and Primary Care Networks should triage patients remotely (to determine the right person and timeframe for managing the problem) in advance wherever possible to help prioritise patient care based on needs; and that clinicians should determine the most appropriate consultation method with the patient - telephone, video, online, face to face. This should be determined by taking into consideration the patient's preferences, needs (including accessibility, privacy, capacity and communication requirements), clinical circumstances and currently, local risks of COVID-19. Whilst we do not have all the clinical details regarding the circumstances surrounding Mrs Pimlott's death, such as her preference of face to face vs remote appointment, we would ordinarily expect the GP practice to have taken the patient's appointment type preference into consideration had they indicated one.

In determining the most appropriate consultation method, considerations regarding patient safety, ability to make a satisfactory assessment, gain a sufficient understanding of the problem and whether information can be provided in a way the patient understands including assessing a patient's understanding of the advice provided should be factors in determining the most appropriate consultation method. If a particular concern did arise following a remote assessment or remote advice being given, then a decision could be made to move to an alternative approach, for example, face to face consultation or for remote advice to be followed up in writing or with the patient's permission with their carer.

Professional guidance published by the General Medical Council sets out high level principles of good practice expected of everyone when consulting and or prescribing remotely for patients https://www.gmc-uk.org/ethical-guidance/learning-materials/remote-prescribing-high-level-principles and guidance to support shared decision making https://www.gmc-uk.org/ethical-guidance/ethical-guidance-for-doctors/decision-making-and-consent.

Additionally, guidance was developed jointly between NHS England and the Royal College of General Practitioners (RCGP) on Remote vs Face to Face: which to use and when? and RCGP publish a range of guidance and learning materials on their Covid-19 Resource Hub. These resources underline the importance of ensuring patient safety, shared decision making and that an individual's needs are paramount.

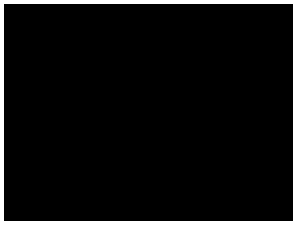
The joint NHS England and RCGP guidance (linked above), which is now in place, refers to the importance of 'safety netting'. I note that the Clinical Commissioning Group medical director that investigated Mrs Pimlotts death indicates that the

consultations that took place where appropriate and safety netting was in place. Every GP practice must continue to provide face to face consultations alongside telephone, video and online consultations as part of making general practice as accessible as possible.

Finally in response to your secondary concern regarding unclear guidance for when GP practices should refer directly to the crisis team, I can confirm that Mental Health services are commissioned locally and to this end I note that the local CCG Medical Director has provided you with a separate response detailing relevant information and confirming steps that have been taken. The CCG are best placed to respond to this concern and they have kindly provided me with a copy of their response, the content of which I note, as well as a copy of the leaflet that has been developed and delivered to all households in the area listing the locally available Mental Health crisis facilities. I note that a reminder is also to be sent to all practices confirming the support available.

Given the steps that have been taken at the local level and the completeness of the response from the CCG, I do not propose responding further on a national level. However thank you for bringing these important patient safety issues to my attention and please do not hesitate to contact me should you need any further information, and in particular if you still consider there to be any issues that require a further national response.

Yours sincerely,



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Interim Chief Executive, NHS Improvement