IN WOKING CORONER'S COURT

BEFORE HER MAJESTY'S CORONER FOR SURREY

THE INQUEST TOUCHING THE DEATH OF MATTHEW EVANS

Response to Regulation 28

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1. H.M. Coroner for Surrey, [redacted], has made a Regulation 28 Report – Action to prevent deaths – dated 18 May 2022 (**"the Regulation 28 Report"**) concerning the death of Mr Matthew Evans ("the Deceased").
2. [redacted] and the Farnham Park GP Practice (**"the Practice"**) respond to the Regulation 28 Report in accordance with Regulation 29 of the Coroners Investigations (Regulations) 2013 ("**the Response**").
3. The Partners at the Practice were awaiting the outcome of the Inquest before undertaking a Serious Event Audit (**"the SEA**"). The Practice Partners considered it appropriate that the SEA took place when it was possible to maximize the number of clinicians attending the audit meeting. The Practice conducted a SEA on Tuesday 31 May 2022. There having been delays due to bereavement, sickness, leave and the various Bank Holidays which interrupted the Practice working timetable, which impacted on the availabilities of the various members of Practice team. Six clinicians participated in the SEA, including [redacted].
4. [redacted] presented the case to all the attendees at the SEA – including the history and his consultations with the Deceased. The Clinicians also went through H.M. Coroner's Inquest findings and the outcome of the Inquest, and the Regulation 28 Report.
5. This is the Response of [redacted] and the Practice to the concerns raised in the Regulation 28 Report concerning both.

"*The GP was not sufficiently proactive with multiple lost opportunities to provide better care and support for Matthew*."

6. [redacted] does not agree. Rather than give a sleeping tablet that would not solve the Deceased's problem on the first consultation, he suggested alternatives.
7. [redacted] focus shifted to a depression and anxiety upon more information becoming available. The prescription of [redacted] is recognized to treat depression and anxiety, and also sometimes causes drowsiness which [redacted] hoped might help the insomnia as well.
8. Treatment with [redacted] and high intensity CBT fell within the NICE guidelines.
9. [redacted] was not in control of when the Deceased was progressed from normal CBT to high intensity CBT, he could only refer to the service.

10. The Deceased did not come close to a referral to the urgent assessment unit.
11. [redacted] a clinical psychologist, gave evidence for TalkPlus. H.M. Coroner invited [redacted] on a number of occasions to conclude that the Deceased should have been referred onwards to secondary mental health services/ the Single Point of Access. [redacted] did not agree, but she thought in hindsight perhaps the Deceased could have been stepped-up to high intensity CBT slightly earlier.
12. In cross-examination [redacted] confirmed:

    (i) [redacted] agreed. that everyone who encountered the Deceased at TalkPlus thought he was an appropriate patient for CBT.

    (ii) It was not unusual to have someone with the Deceased's high scores for depression and anxiety in the service. Neither was it unusual for someone to struggle with CBT at first, and then succeed when stepped up to high intensity CBT.

    (iii) The Deceased's risk remained low throughout. He had no specific plans, and a protective factor in his partner.

    (iv) TalkPlus could and often did refer onwards to the Single Point of Access for secondary care mental health services. The Deceased did not meet the criteria for onward referral. The criteria would involve someone who had a plan to commit suicide or did not have any protective factors. That was based on feedback from the Single Point of Access when refusing referrals.

    (v) There were a lack of options in secondary care for psychological therapy and that was a subject [redacted] had regularly talked to the CCG about.

13. [redacted] has identified a CPD course concerning Mental Health – recognize suicide risks, which he shall be attending by way of reminder and on-going professional development.

14. He will be reflecting on the care and concerns raised by H.M. Coroner in his Appraisal and Personal Development Plan.

The GP did not undertake a mental health assessment to assess the severity of Matthew's difficulties and to ascertain whether further support or referral to secondary mental health care were indicated in any of the four telephone consultations. He did not ask or document at any time if Matthew had any suicidal ideation or acts of self-harm.

15. Whilst [redacted] did not use the PHQ9 or GAD7 questionnaires, he undertook a risk assessment by asking about suicide intent and deliberate self-harming activities or thoughts.
16. [redacted] did not document the risk assessments he made during the consultations. However, he asked about suicidal ideation on 2 and 9 June 2021. [redacted] did not agree that those discussions did not happen. He accepts he did not record this.

17. [redacted] has identified training provided by MDU Serviced Limited which he shall attend, on record keeping, the date for the next course is yet to be confirmed. He has already refamiliarized himself with the GMC Good Medical Practice guidance on record keeping by way of reminder of the standards expected.
18. PHQ9/GAD7 questionnaire will now be sent to patients to complete ahead of their consultations. Scores will be written directly into EMIS Web so available during the consultation with the patient.
19. Safety netting advice must be documented in EMIS Web when given.
20. Accrufix Template created and circulated to all clinicians on where to find GAD & PHQ-9 to detect patient's anxiety and symptoms.
21. See the Action Plan attached.

The GP did not offer a face-to-face consultation or arrange a follow up appointment.

22. No face-to-face consultation was offered, but this was in the context of the GPs at the Practice working in the midst of a pandemic, them having been advised to avoid face-to-face consultations, where possible, in order to reduce footfall.
23. [redacted] (TalkPlus) gave evidence about face-to-face consultations and that, perhaps surprisingly, the evidence did not suggest that face to face therapies were any more effective than telephone. She herself had been surprised during the pandemic at how well someone could be assessed by telephone.
24. [redacted] and the Practice have agreed that patients presenting with new mental health issues, are to be offered face-to-face appointments. This policy was introduced with immediate effect from the date of the SEA.
25. The Practice will review patient follow up timescale and GP should book them in rather than ask patient to call in as they may not be able to get through.
26. See the Action Plan attached.

The GP declined to prescribe Zopiclone and whilst he referred Matthew to the benefits of Melatonin he did not offer a prescription.

27. [redacted] did not offer a prescription for [redacted] to the Deceased when he suggested its use, as the Deceased wanted to think over its use, which was also the case when [redacted] again suggested the use of [redacted] in a later consultation.

He prescribed [redacted] having not done so before for someone in Matthew's position on a background of having no post graduate qualifications in mental health. Furthermore, he did not document any warning of the possible side-effects of this drug including the possible increased risk of suicidal ideation with commencing the drug.

28. [redacted] has prescribed [redacted] before. He was asked by H.M. Coroner whether he had ever prescribed [redacted] to a *middle-aged* man experiencing mental health issues for the first time before. [redacted] confirmed this was the first time he had initiated the prescription of this medication to someone not in a care home (i.e., not elderly).
29. At the SEA the Practice concluded, following full consideration, that [redacted] choice of [redacted] was appropriate given that the Deceased's original primary cause for him contacting the Practice was his insomnia.
30. [redacted] wrote to the CCG prescribing lead on 22 May 2022 and asked as to whether there is any policy regarding the prescription of [redacted] [see Action Plan attached]. She replied on 26 May 2022 that:

    '*there is no CCG guidelines except to prescribe in line with the relevant NICE recommendations, BNF information and NICE CKS guidance. The first line option for depression would be an SSRI but where an SSRI is not suitable,* [redacted] *may be an alternative option to consider'*.

31. [redacted] repeats and relies upon the comments in paragraphs 16 to 20 above.

"It is unclear whether the GP had read the letters from TalkPlus."

32. An Audit of the GP computer system was completed on 31 May 2022. This confirms [redacted] read two of the letters from TalkPlus within 24 hours of receipt, one was received and read within 3 working days. There is a History Trail in Docman which automatically records receipt/read for every document received [see Action Plan attached].
33. The Audit results, analysis and actions recommended have been shared with the Clinical Governance (Lead, Group) of the Practice.
34. See the Action Plan and SEA Report attached.

He did not ask permission as to whether it was possible to inform or involve Matthew's partner and family in his on-going care."

35. Going forward in appropriate situations [redacted] will seek permission to contact and inform family members.

No policy was provided to assist GP's with prescribing of [redacted] *antidepressants and anxiolytics in general practice.*

36. The Practice repeats and relies upon the response at paragraph 30 above.
37. NICE Guidelines on [redacted] prescribing, treatment and information have been circulated. Further guidelines sought from the CCG about depression and anti-depressant

prescribing. All discussed and circulated on 20 June 2022 to all clinicians including Frimley ICS Medicines Optimization Board prescribing guidelines.

38. The Practice will conduct an Audit of patient [redacted] use by August 2022. To present audit results and identity if there is/are action/s required in relation to patient safety i.e. patient education regarding the use of the drug, follow-up to check p[patient remined safe in taking this drug, and does or has the patient required secondary referral to be supported by the community mental heath team.
39. Also see SEA Report and Action Plan attached.

There is no confirmation electronic letters have been signed as read and acted upon by the relevant GP.

40. The Practice repeats and relies upon the responses at paragraphs 32 – 34 above and the SEA Report and Action Plan attached.

No evidence was provided with regard to ongoing training in mental health for GP's.

41. The Practice is liaising with mental health providers to arrange in-house training. The Practice contacted Spires Clare Park, a local hospital which provides private health care on 31 May 2022 to organise Mental Health training. Spire Clare Park have a programme where consultants of various specialties provide educational teaching/meetings for local GPs,. No consultant psychiatrist was available to offer training. The Practice communicated with the mental health lead at the CCG on 21 June 2022 regarding mental health pathways and the Primary Care Network Additional Roles Reimbursement Scheme roles and Cardinal Clinic (a private medical hospital which also provides educational programmes for GPs but they were not able to offer training. A clinical psychologist has been identified who will provide mental health training, which will occur on a date to be fixed when maximum number of clinicians are available to attend. It is hoped this will be sometime during the next couple of months but certainly before the end of the autumn session.

Matthew's death was not investigated or reviewed by the GP practice with the consequence no learning points have been considered or, if necessary, changes implemented, giving rise to concern over the lack of robust clinical governance procedure within the practice.

42. This significant event was discussed on 18 June 2021, two days after it happened at a Partners practice meeting. Further discussions were to be arranged following the Coroner's Report. When the Report was available, the Practice Manager arranged a Significant Event Analysis, inviting all clinical staff members. The date for maximum attendance was chosen as 31.05.2022.
43. The SEA took place on 31.05.2022. See SEA Report and Action Plan attached.

44. The Practice has shared the findings of the SEA with all staff at the practice, the CCG and CQC.
45. Going forward, as part of the Practice's Clinical Governance Policy, it was further agreed that unexpected deaths will be discussed at the Practice Clinical Meetings' Meetings which are held every week and attended by the GP clinicians and Partners.