Ms Karen Henderson
HM Coroner's Court,
Station Approach,
Woking
GU22 7AP

[redacted]

National Medical Director
NHS England
Wellington House
133-155 Waterloo Road Road
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SE1 8UG

[redacted]

Dear Ms Henderson

Re: Regulation 28 Report to Prevent Future Deaths – Matthew John Evans who died on 16 June 2021.

Thank you for your Report to Prevent Future Deaths (hereafter "Report") dated 18 May 2022 concerning the death of **Matthew Evans** on **16 June 2021**. I would like to express my deep condolences to Matthew's family.

I note the inquest concluded Matthew's death was a result of:
1a. Suspension

Following the inquest, you raised concerns in your Report regarding:

1. The actions of the General Practitioner

The GP was not sufficiently proactive with multiple lost opportunities to provide better care and support for Matthew. 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. The GP did not offer a face-to-face consultation or arrange a follow up appointment. The GP declined to prescribe [redacted] and whilst he referred Matthew to the benefits of Melatonin he did not offer a prescription. 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. It is unclear whether the GP had read the letters from TalkPlus. 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.

2. The actions of the General Practice

No policy was provided to assist GP's with prescribing of [redacted] in general practice. There is no confirmation electronic letters have been signed as read and acted upon by the relevant GP. No evidence was provided with regard to ongoing training in mental health for GP's.

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.

The Frimley Integrated Care Board (ICB) have shared their response with me. The NHS Frimley ICB will be carrying out a number of actions following the inquest. I will not repeat these, however would like to reassure you that the ICB will provide confirmation to the Regions of their completion. An NHS England Region is an integral part of NHS England. It is a sub-division of NHS England's Operations and Information Directorate, and is responsible for the quality, financial and operational performance of all NHS organisations in their region.

In response to receiving your Report, NHS England has taken action to refer Farnham Park GP to NHS England South East region's Professional Standards team, under NHS England's 'Responding to Concerns' framework and any additional actions arising that are required to address the concerns of the coroner, will be overseen and followed though by the NHS England South East region's Professional Advisory Group.

The NHS England Kent, Surrey and Sussex regional team will be convening a **Performance Advisory Group** (PAG) as part of NHS England » Responding to concerns procedures. A PAG is a small, local panel of people who are tasked with carrying out or directing the scope of investigatory and advisory work relating to concerns about doctors on the Performers Lists. Any additional actions arising to address concerns of the practitioner will be considered further in the PAG.

I have pulled out the main points from the concerns raised regarding the actions of the General Practitioner and the General Practice. I am unable to comment on the specific details of the actions of the GP and practice. However, I have highlighted guidance that relate to these points.

1. The actions of the General Practitioner

a) The GP did not undertake a mental health assessment to assess the severity of Matthew's difficulties

There are several educational resources and guidance documents relating to the assessment and treatment of depression that are accessible to clinicians.

The National Institute for Clinical Excellence (NICE) supports clinicians with Clinical Knowledge Summaries in many areas including assessment and treatment of depression. This guidance also covers the prescribing of mirtazapine and antidepressants and anxiolytics.

NICE have also recently updated their guidance on "Depression in adults: treatment and management guidance"(29th June 2022): The latest draft of this update is available to view at https://www.nice.org.uk/guidance/indevelopment/gid-cgwave0725/documents.

More detailed guidance on the prescribing and use of specific antidepressants including Mirtazapine is published by the British National Formulary (see https://bnf.nice.org.uk/drugs/mirtazapine/) and also as part of the SmPC available at https://www.medicines.org.uk/emc/medicine/26391/SPC/Mirtazapine+30mg+Tablets

RCGP position statement on mental health in primary care - September 2017 advises:

"common mental health problems are managed using the approach recommended by NICE. GPs should manage patients using a combination of medication, psychological therapies, support groups, befriending, rehabilitation programmes, educational and employment support services and referral for further assessment and interventions in secondary care if needed.

GPs should be aware of the issues around confidentiality and suicidal ideation. In line with good practice, practitioners should routinely confirm with people whether and how they wish their family and friends to be involved in their care generally"

b) The GP did not offer a follow up appointment

The Quality and Outcomes Framework (QOF) indicator (DEP003) for depression for 2021/22 states the following requirement:

The percentage of patients aged 18 or over with a new diagnosis of depression in the preceding 1 April to 31 March, who have been reviewed not earlier than 10 days after and not later than 56 days after the date of diagnosis

This recommendation is based on NICE guidance on depression in adults. It recommends that patients with mild or moderate depression who start antidepressants are reviewed after one week if they are considered to present an increased risk of suicide or after two weeks if they are not considered at increased risk of suicide. Patients are then re-assessed at regular intervals determined by their response to treatment and whether or not they are considered to be at an increased risk of suicide.

c) The GP did not offer a face-to-face consultation

During the Covid-19 pandemic, a greater number of consultations took place remotely with the aim of keeping patients and staff as safe as possible from Covid-19. This was in line with the NHS England guidance at that time:

https://www.england.nhs.uk/coronavirus/documents/advice-on-how-to-establish-a-remote-total-triage-model-in-general-practice-using-online-consultations/#intro

However, on 13th May 2021 NHS England wrote to GP practices with information about an updated version of the standard operating procedure (SOP) to support restoration of general practice services SOP (england.nhs.uk). This was in anticipation of government changes to social distancing from 17 May 2021. This advised that GP practices must all ensure they are offering face-to-face

appointments and that patients and clinicians have a choice of consultation mode. The full SOP was published on 19 July 2021 .

2. The actions of the General Practice

a) No policy was provided to assist GP's with prescribing of Mirtazapine and antidepressants and anxiolytics in general practice

As stated above, there are several guidance documents to support clinicians in the assessment and treatment of depression. These include NICE guidance, Clinical Knowledge Summaries and the British National Formulary.

GPs undergo training in mental health as part of the GP trainee scheme as well as during ongoing continuing personal development (CPD). Ongoing learning is expected as part of the GMC's appraisal and revalidation processes. As a result, GPs are usually experienced with the assessment and treatment of depression.

b) No confirmation electronic letters have been signed as read and acted upon by the relevant GP

Incoming correspondence should be read by either the appropriate GP or another member of the primary care team. In relation to managing correspondence and test results, the Care Quality Commission updated its guidance on 24th May 2022:

Robust practice protocols and standardised processes can protect patients. We expect to see that practices have an agreed and documented approach that every member of the practice team understands. Practices can develop their own systems and protocols to safely manage test results. They must be able to demonstrate their effectiveness.

To free up clinical time not all correspondence needs to be seen by the GP but can be managed by trained non-clinicians when appropriate.

c) 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.

National guidance for reporting and investigating serious incidents is available online: Guide for general practice staff on reporting patient safety incidents to NRLS (2015) and Serious Incident Framework 2015. There is a clear definition of what constitutes a serious incident which includes acts or omissions in care that result in; unexpected or avoidable death (including suicide), and unexpected or avoidable injury resulting in serious harm.
Once a serious incident is reported, NHS commissioners have responsibility to quality assure the robustness of their providers 'serious incident investigations and the action plan implementation. Commissioners are responsible for oversight and closure of serious incidents from all commissioned providers; these include acute, community, mental health, primary care, and independent providers

Primary care (including GP practices) must have effective clinical governance, which includes discussions on unexpected deaths and significant events, both positive and negative.

- See GP mythbuster 3: Significant Event Analysis (SEA).
- See GP mythbuster 65: Effective clinical governance arrangements in GP practices | CQC Public Website.

Future actions

The NHS patient safety strategy published in 2019, set out goals for patient safety improvement in incident recording, incident response and primary care. The NHS England » Learn from patient safety events (LFPSE) service was launched in July 2021, enabling primary care to record incidents and other safety events via the new service. As LFPSE is rolled out across the NHS in 2023, all providers will be expected to record their incidents via this system.
Alongside changes to incident recording, the NHS England » Patient Safety Incident Response Framework PSIRF) outlining how providers should respond to patient safety incidents and how and when a patient safety investigation should be conducted, will commence in Summer 2022. Initially, the PSIRF implementation is focused in secondary care and pilots will be undertaken in primary care after this to develop the framework effectively for primary care. The PSIRF promotes systematic, compassionate, and proportionate responses to patient safety incidents, anchored in the principles of openness, fair accountability, learning and continuous improvement – and with the aim of learning how to reduce risk and associated harm. The PSIRF recognises that meaningful learning and improvement following a patient safety incident can only be achieved if supportive systems and processes are in place. The PSIRF supports development of a patient safety incident response system that prioritises compassionate engagement and involvement of those affected by patient safety incidents.

This report will be provided to the Regional Mortality Boards so that they may share it with all ICBs to ensure that they are able to learn from this event.

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.

Yours sincerely,

[redacted]

[redacted]
National Medical Director
NHS England