IN THE INNER LONDON SOUTH CORONER'S COURT

IN THE MATTER

TOUCHING INTO THE DEATH OF

MASTER OMARIAN BROOKS

DR [redacted], ON BEHALF OF SYDENHAM GREEN GROUP PRACTICE,

RESPONSE TO CORONER'S PREVENTION OF FUTURE DEATH REPORT

Background:

1. The response to the Coroner's Prevention of Future Death Report dated 29 May 2020 are made on behalf of Dr [redacted], an interested person pursuant to section 47 (2) (g) or (m) of the Coroner's and Justice Act 2009 ("the Act"). These are made on behalf of Dr [redacted] and the Sydenham Green Group Practice ("the Practice"), as the parties relevant to Dr [redacted] to whom a report might be addressed. Dr [redacted] and the Practice will be referred collectively as "the GPs" except where it is necessary to distinguish the two.

2. The Inquest took place on 10th and 13th January 2020 at the Inner London South Coroner's Court following the death of Master Omarian Brooks who died aged 11 years on 28th May 2017. The Learned Coroner has provided the Record of Inquest and conclusions and findings of fact on 23rd January 2020.

3. The Learned Coroner in their Prevention of Future Deaths report raised matters of concerns:

Matters of Concern:

1. The Record concludes that had the GP been informed of the boy's deterioration either 4 days before the antibiotic was started or soon after, he would have been admitted to hospital with a real prospect of the infection being successfully treated.

4. The GPs have implemented a policy for circumstances where 'rescue pack' antibiotics are prescribed to patients with complex needs on a repeat basis. This policy includes an agreement which has to be made between the GPs and the parents. This agreement

states the parents must telephone the GP Practice on the first day that they start their children on the antibiotics. This allows for the named GP to record in the patient's notes that they have started on antibiotics. We enclose a copy of the policy to the response.

5. The GPs held a Practice Meeting on 29 June 2020 following on from the Coroner's conclusion and the Prevention of Future Deaths report. We enclose a copy of the Practice Meeting notes for your reference.

6. The GPs discussed during their meeting developing and putting in place a quarterly meeting to discuss children aged 5-18 with complex medical needs who are not discussed as part of the Health Visitor MDT aged 0-5 or the Palliative Care/Community MDT ages 18+. The GPs envisage that most of the Practice's GPs attend this and each bring a small number of cases to be discussed. The GPs have scheduled to have a quarterly meeting in September 2020.

7. As a result of Omarian's death, all children who are coded as having complex needs have been allocated to a named GP. Therefore, any correspondence relating to these patients are to be brought to the attention of that named GP. In order to ensure that these patients have been allocated a named GP, the GPs are planning to undertake audits on a monthly basis to confirm that this change has been implemented. The most recent audit to confirm the implementation took place on 8 July 2020 and is enclosed to this response. The named GP is also to consider discussing with the families of the children whether they should have a Coordinate My Care plan in place to share treatment plan with other services.

8. In situations where a GP receives a request for rescue antibiotics or similar from a hospital or Community Consultant, they are to clarify exactly what is being covered and ask the Consultant to send a shared care style agreement to formalise the arrangement.

9. Following the Practice Meeting a search for children with multiple complex needs was undertaken and identified eight children within the Practice. Further examination of their notes was undertaken to ensure that the code 'has a carer' was recorded, and then cross referenced with their registered parents/guardians so that in each of their notes, it was coded that they were 'a carer'. Each child was then allocated a named GP. The GP was informed, and it was highlighted as an alert on the child's records.

10. The named GP, as per the recommendations received from Lewisham Clinical Commissioning Group, was also changed to align with their allocated named GP for this purpose. The search is run every month during the Children Safeguarding MDT meeting. Since the GPs have started this process, one further child has been added to the register. The GPs hold the register of children with named GPs in a shared drive that is accessible to all clinicians.

11. Dr [redacted] provided a witness statement to the Coroner at the Inquest in January 2020. Dr [redacted] submitted an Action Plan which the GPs had formulated following the Serious Case Review on 4 July 2019. The GPs has now implemented the changes proposed in the Action Plan, in particular, that children with complex needs are to have at least one named GP. We enclose a copy of the completed Action Plan to this response.

2. *There was also a distressing dispute between the ambulance crew and parents as to which hospital Omarian should be taken, in the event he was not taken to the nearest hospital at the insistence of his parents (although in this instance the delay was not found to have contributed to the death).*

12. The Coroner comments in their PFD report under 'Action Should Be Taken' that *"Accordingly these agencies and the local hospital are the subject of the report as in my opinion their joint action should be taken to prevent future deaths."* In light of the Coroner's concerns, a multi-agency meeting took place on 14 July 2020. The purpose of the multi-agency meeting was to discuss the PFD Report and the concerns raised by the Coroner in order for a joint response to be prepared.

13. During the multi-agency meeting Dr [redacted] was able to feedback to the agencies what changes have been implemented at the Practice following the Coroner's conclusions, such as, the new Practice policy regarding antibiotics and the named GP system for children with complex needs. By updating the other agencies, it enabled for further discussions to be generated about how they could impact on the changes made by the GPs. For example, there was a discussion with Lewisham CCG in respect of every Practice across Lewisham having a designated GP for children with complex needs.

14. There were also lengthy discussions during the multi-agency meeting in respect of 'Coordinate My Care'. This has been raised by other agencies as a way to have access to patient information from different agencies. The Practice has CMC embedded into their medical records system. The GPs have been using CMC regularly since its inception in 2015 for adult patients as a platform to share medical information with outside agencies such as London Ambulance Service, 111 and the local hospice. Unfortunately, the CMC was not available for children during the time of Omarian's life. The GPs report that CMC is now available for children under the age of 18. The GPs have subsequently worked through CMC already with one family in the practice who have specific medical needs and will continue to offer it to all patients going forward.

15. As the GPs now allocate patients with complex needs to a named GP this means that there is a point of contact for CMC. This will allow for better communication between the different agencies. Therefore, if there are any requirements such as a specific hospital which the parents have requested then that can be made clear to other agencies involved in the patient's care.

Summary

16. The GPs have worked hard to implement changes to ensure that the concerns which have been raised by the Coroner have been addressed. The Coroner had concerns in respect of the GP's lack of awareness that Omarian had started a course of antibiotics and were also unaware of Omarian's subsequent deterioration. The Practice want to guarantee that where there are cases similar to Omarian's that the appropriate safety netting measures are in place.

17. There were important discussions at the multi-agency meeting which were greatly beneficial for the GPs. It allowed for there to be discussions relating to how the Practice can implement changes and how other agencies can support those changes. The Learned Coroner will note that a multi-agency response has been formulated which gives an overview of how each agency has implemented their own changes and also how they are working together to ensure there is effective co-ordination between the different agencies. The GPs are committed to having a coordinated multi-agency approach to future patients.

5 August 2020

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Sydenham Green Group Practice Procedures & Protocols

Protocol for the Prescription of "Rescue pack" Antibiotics in Children

Date: July 2020
Review due: January 2021

Summary.

The prescription and use of rescue pack antibiotics in children is not a common occurrence. The development of this protocol is to ensure that all GPs in the practice have a framework to aid them through safe decision making in the prescribing process.

- The prescription of rescue pack antibiotics will only be undertaken upon the advice of a secondary care clinical team.
- The GP will clarify that these instructions are clear and are accompanied by a clear care plan.
    - Key areas that must be recorded and discussed with the family are; when the GP is to prescribe these antibiotics, when they should be started by the family, when the family is to inform the GP that the antibiotics have been started, and at what stage after antibiotics are commenced that follow-up by the GP is required.
- Internal follow-up will occur within the GP practice to ensure that the named GP for the child is aware that the child has been commenced on the course of rescue pack antibiotics.
- Timely review of the ongoing availability of rescue pack antibiotics. Medication reviews are undertaken at least once yearly in primary care. We should expect information from the secondary care clinician as to whether the use of rescue pack has been reviewed by their team. If not, we will no longer be prepared to carry on prescribing rescue pack antibiotics.

Minutes of Doctors Meeting

29th June 2020

Present:
GP: [redacted]
Trainee: Dr [redacted]
Nurse: [redacted]
Manager: [redacted]

The meeting was held to discuss the Coroner's report into the death of Omarian Brooks (DOB 27-02-2006, DOD 27/05/2017). The Coroners judgement and Preventing Future Deaths report are below:

BrooksOmarian PFD V2docx.docx

Brooks O Judgment.docx

The relevant section of the PFD report is as follows:

ACTION SHOULD BE TAKEN

It is not for the court to determine whether earlier admission to hospital of potentially septic disabled children is achieved by a Patient Specific Protocol or Child in Need Plan or by way of mandating informing the general practice that antibiotics had been started, or a combination of these or other forms of multi-disciplinary care. Accordingly these agencies and the local hospital are the subject of the report as in my opinion their joint action should be taken to prevent future deaths. It is not clear that the steps taken by the general practice for the duty doctor to inform colleagues of a consultation, nor the action plan by the Borough implementing the recommendations of the SCR, which refers to standby antibiotic usage (and not communications with the GP), and does not specifically involve the London Ambulance Service can be relied upon to prevent such a death recurring. Some information was submitted after conclusion of the inquest by L&G NHS Trust, which had not been admitted as evidence and may usefully be part of the response to the report. I believe that these organizations would wish to learn of the evidence given in the inquest about the circumstances of this death and can mitigate or prevent future deaths by articulating their joint action.

The suggestion is that the practice should work with other parties (London Ambulance Service, Lewisham & Greenwich NHS Trust) to coordinate a response. To that end NHS South East London CCG have been approached for support. In the interim, the practice has discussed the following:

1. Developing and putting in place a quarterly meeting to discuss children aged 5-18 with complex medical needs who are not discussed with as part of the Health Visitor MDT ages 0-5 or the Palliative Care / Community MDT ages 18+. It is envisaged that most SGGP GPs attend this and each bring a small number of cases to be discussed. Dr [redacted] to coordinate the list of patients covered.

2. As a result of this death, all children coded as having complex needs have been allocated to a named GP. Letters for these patients are to be brought to the attention of that named GP as they are found. The named GP is also to consider discussing with the families of the children whether they should have a Coordinate My Care plan in place to share treatment plans with other services.

3. Where a GP receives a request for rescue antibiotics or similar from a hospital or community consultant they are to clarify exactly what is being covered and ask the consultant to send a shared-care style agreement to formalise the arrangement.

4. Dr [redacted] is to approach the CCG, LAS and UHL to organise a meeting to discuss a more systemic response as the steps above would need to be acted on in a borough/SEL-wide basis to have a meaningful impact.

NHS
Lewisham
Clinical Commissioning Group

8th January 2020

Letter to General Practitioners,

Dear Colleagues,

I write to draw your attention to the recommendations of a Serious Case Review undertaken by Lewisham Safeguarding Children Board.

The review was undertaken following the sad death of an 11 year old boy who did not survive a cardiac arrest while on transfer to hospital. He and his family were known to social, primary, secondary and tertiary services due to his complex medical and health needs and there had been known concerns around the relationship between health partners and the child's carers.

The findings of the review panel identified learning for all agencies involved in the care of the child. The two key recommendations for GP practices across Lewisham borough are shared here:

- The importance of a co-ordinated approach for children with complex needs. This resonates with other Serious Case Reviews both locally and nationally.

In order to support a coordinated approach it is a recommendation of the review that a child with complex health needs has one or two named GP's identified within their registered practice. This will provide continuity of care for the child and carers and help practices to have clear oversight of the care provided.

- In addition it was recognised that a conscious process needs to be in place to consider the health of carers of a child with complex medical and health needs and how this will impact on the outcome for children. While a full medical for such carers is best practice, we recognise this is currently not commissioned. Lewisham CCG will raise this issue with NHS England.

In the meantime, we ask that you are mindful of the health of such carers in your contacts with children, in order to have a clear picture of the lived experience of the child.

We would be grateful if these two recommendations taken on board and processes put in place to implement them and improve the outcomes for children with complex medical and health needs

Yours sincerely

[redacted]

Director of Nursing and Quality

Date of Last Search	EMIS	DOB	Named GP
08/07/2020	507756	22/03/2013	MH
	500771	23/05/2009	WM
	508032	17/12/2018	JFB
	45253	12/08/2010	MW
	48585	24/08/2006	NH
	44894	24/05/2010	TQ
	35322	10/11/2005	AK
	503088	10/06/2014	ES
	1104872	29/01/2019	JP

CHILD X	RECOMMENDATION	ACTION	LEAD (POST)	COMPLETION DATE	EVIDENCE (PROGRESS OF RECOMMENDATIONS TOD ATE)	OUTCOME (WHAT ARE THE EXPECTED IMPROVEMENTS IN PRACTICE)	RAG RATING
6.1	A clear protocol in place for children who miss immunisations Audit of the protocol over a 3 month period		Practice Safeguarding lead	6 Months	 Missed Immunisation Protocol.jpg	 Imms Audit 2020.pdf	GREEN
6.2	An audit of vulnerable family meetings over a 6 month period to assess whether actions from the meetings are being taken.		Practice Safeguarding lead	6 months	 Audit MDT HV (2).pdf		GREEN
6.3	An audit to check whether children with complex needs have parents identified as carers		Practice safeguarding lead	3 Months	Commenced and verbal report given	 Audit. Parents as carers.pdf	GREEN
6.4	A clear protocol of following up on children on the emergency duty list where a GP is unable		Practice safeguarding lead	3 MONTHS		 Protocol for emergency duty list.p	GREEN

	to make contact with parents on that day.						
CHILD X	**RECOMMENDATION**	**ACTION**	**LEAD (Post)**	**COMPLETION DATE**	**EVIDENCE (Progress of recommendations to date)**	**OUTCOME (What are the expected improvements in practice)**	**RAG RATING**
6.5	Children with complex needs to have one or two named GPs	Allocation at practice level by practice child safeguarding leads.	All GP practices in Lewisham NHS CCG	6 MONTHS	Letter to inform GP practices of this recommendation has been completed and signed off by Director of Quality and Nursing for Lewisham CCG	Lewisham CCG letter to GP's.pdf Letter distributed to GPs February 2020	GREEN
6.6	Consideration of annual health check for carers of children with complex needs	Recognition by practice child safeguarding leads	All practices in Lewisham NHS CCG		Letter to NHS England re commissioning of health checks has been completed and signed off by the Director of Quality and Nursing for Lewisham CCG	Lewisham CCG letter to [redacted] NHSE.p Lewisham CCG letter to [redacted] NHSE.pdf Letters sent to NHSE February 2020	GREEN
	Inclusion of themes arising from this case to be used as part of child safeguarding training in Lewisham	Prepare child safeguarding training material on	Named GP for child safeguarding in Lewisham CCG	2 MONTHS			GREEN

	CCG	children with complex needs.			 SCR X briefing.pdf Training material adapted to include themes arising from this case		