Heathview Medical Practice

[redacted]

Glascote Health Centre,
60 Caledonian,
Glascote
Tamworth
Staffs. B77 2ED

Stonydelph Medial Practice
55 Ellerbeck,
Stonydelph,
Tamworth
Staffs. B77 4JA

Wilnecote Surgery
Parson Street,
Wilnecote
Tamworth
Staffs. B77 5BD

[redacted] [redacted] [redacted]

4TH November, 2022

Coroner's Office,
1 Staffordshire Place,
Stafford. ST16 2LP

Dear Sirs,

RE; REFERENCE ARB/EAS 12533072

Further to your recent correspondence regarding the above please find the enclosed:-

1. Report following the inquest to prevent future deaths
2. Significant Event Analysis
3. Overdose Policy

Yours faithfully,
Heathview Medical Practice

[redacted]

The Partners

REPORT FOLLOWING CORONER'S INQUEST TO PREVENT FUTURE DEATHS

The Heathview Medical Practice, Tamworth have been requested to provide a report following the coroner's inquest into the death of Eirwen Rebecca Hollister.

Circumstances of the Death:

This patient was registered at Heathview Medical Practice in Tamworth but was also simultaneously registered at Sutton Coldfield group Practice between 21st September 2021 and end of February 2022. She was receiving medication from both practices during this time. To date there is no clear explanation how this has occurred.

On 21st March 2022 she took an overdose, was assessed by paramedics at her home, and declined admission. She undertook a further overdose on 22nd April 2022 and was taken to Good Hope Hospital and discharged on 24th April 2022.

During the time between the overdoses she was prescribed weekly medications but was not reviewed by the practice.

She was found deceased at her home address on 10th May 2022.

Concerns raised:

- The practice has a clear policy concerning overdoses, which states that medications will be switched to weekly issues and the patient has to be reviewed by a clinician before issuing of medication. In this case the medication was issued weekly, however the patient was not reviewed following the overdose.
- The patient was registered at two different GP Practices simultaneously and receiving medications from both Practices.

Actions taken by practice:

- We have carried out a significant event analysis to identify any failings and learning points. The results of the significant analysis were discussed with all clinicians in a meeting on 21/10/22. Please find attached a copy of the significant event analysis.
- The 'Overdose Policy' has been reviewed and discussed with all clinicians at Heathview Medical Practice on 21/10/22. The Policy is on the shared drive and can be accessed by all staff. Please find attached a copy of the Policy.
- Teaching has been carried out to all clinical staff on how to action Docman letters (Clinical letters from Hospital) which involve overdoses on 21/10/2022
- The Policy and the significant event will be discussed with all the staff in a practice meeting on 15th November 2022
- We have contacted NHS registrations; however, they could not explain how a patient managed to register at two different practices simultaneously and are looking into this.

Conclusion

The Practice will continue to be transparent and abide by its duty of candour.

Although there is a clear policy in place concerning overdoses, which consists of two parts (switching to weekly medications and reviewing the patient before medications issued), the first part of the policy was followed but not the second part.

Significant event analysis, policy review, teaching, and discussion has been carried out to prevent recurrence of this event and to ensure all parts of the policy are followed.

On behalf of Heathview Medical Practice, Tamworth.

SIGNIFICANT EVENT ANALYSIS

PRACTICE NAME: Heathview Medical Practice
DATE OF MEETING: 11.10.2022- 24/10/22
MEETING ATTENDEES: GP Partners, PM, Assistant PM, Associate Partners

DATE OF INCIDENT 10/5/22 (21/3/22, 22/4/22) **TIME OF INCIDENT**
SIGNIFICANT EVENT RAISED BY:- [redacted]

WHICH OF THE FOLLOWING BEST DESCRIBES THE INCIDENT?					
Prescribing, Dispensing X	**Vaccs & Imms**	**H/Vs, OOH, Emergencies**	**Communication within team/external**	**Path Reports**	**Appointments**
Medical Records X	**Confidentiality**	**Secondary Care**	**Violence & Aggression**	**Other**	

WHAT HAPPENED?	This patient was registered at Heathview Medical Practice in Tamworth but was also simultaneously registered at Sutton Coldfield group Practice between 21st September 2021 and end of February 2022. She was receiving medication from both practices during this time. To date there is no clear explanation how this has occurred. On 21st March 2022 she took an overdose, was assessed by paramedics at her home, and declined admission. She undertook a further overdose on 22nd April 2022 and was taken to Good Hope Hospital and discharged on 24th April 2022. During the time between the overdoses she was prescribed weekly medications but was not reviewed by the practice. She was found deceased at her home address on 10th May 2022.
WHY DID IT HAPPEN	Practice Policy concerning overdoses: 1. Switch to weekly medications 2. Patient to be reviewed before issued. Weekly medications in place but patient was not reviewed. The patient had been reviewed by paramedics and also by the hospital who had stated that patient was not suicidal. The clinicians from the practice relied on this rather than carry out their own reviews.

WHAT WAS DONE WELL?	Weekly medications. Alerts were put on the patient notes Regular reviews had been carried out prior to the last two overdoses
WHAT COULD HAVE BEEN DONE DIFFERENTLY AND WHO WAS INVOLVED IN THE DISCUSSION	Patient should have been reviewed before medication issued as per practice policy.
WHAT HAVE YOU AND YOUR TEAM LEARNT?	Although Policy in place the patient was not reviewed. The patient had been reviewed by paramedics and also by the hospital who had stated that patient was not suicidal. The clinicians from the practice relied on this rather than carry out their own reviews- Clinicians should not rely on this and adhere strictly to the policy of the practice.
WHAT CHANGES HAVE YOU OR THE ORGANISATION MADE?	This case has been discussed with all clinicians at the practice. The Policy has been reviewed and teaching carried out on this. Docman (clinical letters from Hospital) teaching and training has been carried out at the practice.
OTHER COMMENTS/REVIEW DATE IF APPLICABLE	The above actions taken should prevent recurrence.

Heathview Medical Practice

Policy Regarding Overdose

Introduction

This policy is regarding patients who have presented with overdose. They may have been discharged from hospital or seen by any other service.

AThe practice will:

1. Switch medications to weekly medications upon receipt of overdose notice.
2. Patient is to be reviewed by a clinician before medication is issued.
3. Alert to be added on to records.

[redacted]

Next review October 2024