Response to Report to Prevent Future Deaths

THIS RESPONSE IS BEING SENT TO: Daniel SHARPSTONE, Assistant Coroner for the coroner area of Suffolk.

1. Respondent

Clinical Director, Unity Healthcare. In line with our duty under Regulation 29 of the Coroners (Investigations) Regulations 2013, Unity Healthcare provides this response to the Report to Prevent Future Deaths.

2. Date of response

Wednesday 13th May 2026

3. Confirmation of coroner's matters of concern

Unity Healthcare formally acknowledges the two matters of concern raised following the inquest into the death of Melanie Ruth Pinnell:

- No follow-up was offered to Melanie by the GP practice after February 2025 despite Melanie describing suicidal ideation and suicidal thoughts.
- The request for Sertraline once a day given by a Consultant Psychiatrist to the Primary Care Network Mental Health Care Worker was not actioned by a GP working for Unity Healthcare.

4. Investigation and reflection

Unity Healthcare wishes to express its deepest sympathies to the family and friends of Melanie Pinnell.

Following this incident, we commissioned a comprehensive Patient Safety Incident Investigation (PSII) in accordance with the NHS Patient Safety Incident Response Framework (PSIRF). The investigation utilised system-based analytical tools, including the Systems Engineering Initiative for Patient Safety (SEIPS) and the Yorkshire

Contributory Factors Framework (YCFF). We engaged openly with the Norfolk and Suffolk Foundation Trust (NSFT) and the Primary Care Network (PCN) to fully understand the systemic vulnerabilities that contributed to this outcome.

The investigation concluded that the incident arose from a combination of interacting system factors rather than individual error. Specifically, the required protocol for prescribing queries (the "pink internal query hub slot") was bypassed in favour of an individual "task," making the clinical request invisible to the wider team. Furthermore, complex organisational boundaries between the Practice, PCN, and the Norfolk and Suffolk NHS Foundation Trust (NSFT) resulted in gaps in accountability for actioning specialist advice and a lack of systematic safety-netting for vulnerable patients.

5. Details of action taken or proposed

Based on our PSII findings, we are implementing the following safety actions with specific oversight and timelines:

Addressing Concern 1: Gaps in Follow-up and Safety-Netting

- **Formal Caseload Reviews**: We are introducing a formal caseload review between the practice and the Mental Health team to review plans and safety-net actions. This is owned by the PCN MH Service Lead and GP Clinical Lead for mental health.
- **Managing Uncontactable Patients**: We are standardising the process for managing uncontactable patients by developing and implementing a new Standard Operating Procedure (SOP).

Addressing Concern 2: Un-actioned Prescription Requests and Task Limitations

- **Removing Task-Based Prescribing**: We are removing the use of the task system for prescribing requests entirely and developing an approved, formal pathway SOP.
- **System Recording**: To ensure visibility, all specialist advice will be recorded in both of our clinical systems, SystmOne and Lorenzo.
- **Defining Ownership and Escalation**: The PCN MH Clinical Lead and GP Clinical Lead for mental health are defining and re-enforcing clear ownership for prescribing actions and follow-up, as well as introducing a formal escalation SOP for incomplete actions.

Outstanding Task Review System: A review system for outstanding tasks—specifically ensuring visibility of tasks assigned to locums, absent staff, or staff who have left the organisation—was implemented by Clinical Services Management in June 2025.

6. Shared learning

To ensure wide-reaching impact, the findings and new SOPs will be presented internally at Unity Healthcare clinical meetings. Furthermore, an anonymised summary detailing the risks of task-based messaging for prescribing requests will be shared with the Suffolk and North East Essex Integrated Care Board (ICB) Quality Lead to promote shared learning across the wider system.

7. Statement of truth

I believe the facts stated in this response are true to the best of my knowledge and belief.

Clinical Director, Unity Healthcare