REGULATION 29 RESPONSE TO A REPORT ON ACTION TO PREVENT FUTURE DEATHS

Please do not include any living person names in this document, in accordance with the Chief Coroner's publication policy PDF.

THIS RESPONSE IS BEING SENT TO:

The Senior Coroner, [X] for the Coroner Area Cheshire in response to a '**REPORT TO PREVENT FUTURE DEATH REGULATION 28**' following an investigation into the death of **Bethany Kate HEWITT**, and an inquest that concluded on **02 July 2026**.

1.	**RESPONDENT** In line with our duty under Regulation 29 of the Coroners (Investigations) Regulations 2013, **Grove House Practice** provides this response within 56 days of the date of the Report to Prevent Future Deaths or any extension granted.
2.	**DATE OF RESPONSE 13th August 2026**
3.	**CONFIRMATION OF CORONER'S MATTERS OF CONCERN** The **MATTERS OF CONCERN** were identified in the report are as follows: 4) The letter from the ADHD service on the 19 November 2024 refusing the request for an expedited ADHD assessment due to "insufficient evidence being provided within the form", that was sent to Grove House Medical Practice, was not placed before a GP for review. It remained in Ms Hewitt's notes. I am concerned that there is a risk that important external communication is not reviewed by GP's at the Grove House. 5) Follow up appointments were not always offered by GP's at Grove House Medical Practice. In evidence at the inquest, a GP from the practice was unsure if there were NICE guidelines that recommend when GP's should offer follow up appointments after mental health consultations and was not aware if there was a practice policy in relation to follow up appointments after a mental health consultation. I am concerned that there is a risk that mental health is not always monitored so that timely referrals can be made to secondary mental health services. 6) The "Right to Choose" option for an ADHD assessment was not offered until the 3rd February 2026, which was almost 3 years after the initial

	referral for a diagnostic ADHD assessment. It was known at the time of the initial referral for a diagnostic ADHD assessment, that there were long waiting times for an assessment. I am concerned that there are missed opportunities to request an ADHD diagnostic assessment under the “Right to Choose” option which may enable an earlier assessment.
4.	**DETAILS OF ACTION TAKEN** A Significant Event Analysis (SEA) was initiated immediately following notification of the patient's death in February 2026. As part of the Practice's clinical governance arrangements, the unexpected death of a young adult without an immediately apparent cause is routinely reviewed to identify learning and ensure all aspects of the patient's care are fully considered. The Practice has a robust Significant Event Analysis process that supports continuous learning and quality improvement. The SEA process establishes the facts surrounding an event, undertakes a thorough investigation, identifies learning, implements actions and reviews those actions to ensure they have been completed and have achieved the intended improvements before the event is formally closed. This SEA remains open to ensure that all agreed actions are fully implemented, monitored and embedded into practice. Progress is reviewed regularly through the Practice's Clinical Governance meetings, where learning is shared, actions are evaluated and further improvements identified where appropriate. As part of this process, the Senior Partner and Practice Management Team have met with Cheshire and Merseyside Integrated Care Board (ICB) to review the Coroner's concerns, discuss the actions being taken by the Practice and consider wider system learning. In addition, the Practice has completed a detailed report regarding this incident, which has been submitted to the Care Quality Commission (CQC). **MATTERS OF CONCERN** *4) The letter from the ADHD service on the 19 November 2024 refusing the request for an expedited ADHD assessment due to “insufficient evidence being provided within the form”, that was sent to Grove House Medical Practice, was not placed before a GP for review. It remained in Ms Hewitt’s notes. I am concerned that there is a risk that important external communication is not reviewed by GP’s at the Grove House* I. The Practice has a well-established correspondence management system, developed and refined over several years to support the safe and efficient management of the increasing volume of clinical correspondence received by the Practice. This process continues to be reviewed regularly including regular audits which are undertaken by a GP partner for oversight ensuring correspondence is managed safely whilst enabling GPs to maximise time available for direct patient care. Whilst there is a process in place, learning from this Significant Event Analysis has identified an opportunity to strengthen this process further. The correspondence management policy has been amended to ensure that any correspondence relating to the outcome of a referral, including requests for expedited assessments that are declined or where further information is requested, is allocated to a GP for clinical review. This

	will ensure that the patient's ongoing clinical risk is reconsidered, any additional information can be provided where appropriate, and a clear follow-up plan is agreed. II. The Practice has reviewed this concern as part of its Significant Event Analysis and recognises that there is currently no nationally agreed pathway or NICE guidance specifically relating to the management of rejected requests for expedited ADHD assessments. Whilst clinicians assess and manage patients in accordance with relevant NICE guidance for their presenting condition, the Practice would welcome clearer national guidance regarding ADHD referral pathways, expedited referral criteria and the management of patients whose condition deteriorates whilst awaiting assessment. On 29th July 2026, the Senior Partner and Practice Management Team met with Cheshire and Merseyside Integrated Care Board (ICB) to discuss the learning from this case, including the management of expedited ADHD referrals. During this meeting, the ICB shared details of the new Adult ADHD Local Enhanced Service, due to be implemented across Cheshire and Merseyside during 2026/27. The ICB advised that, *"as part of the development of the Local Enhanced Service we have developed a set of self-help resources available on the ICB website that patients can be directed to while they wait."* The Practice welcomes this development and will actively engage with the new service model, associated guidance and supporting resources as they become available. III. The Practice has previously engaged with Mersey Care NHS Foundation Trust regarding local mental health services. As part of the ongoing actions arising from this Significant Event Analysis. The Partners and Practice Management Team will seek a further meeting with Mersey Care to clarify the criteria required to expedite an ADHD referral, successfully into the services to deteriorating patients and how communication between primary and secondary care can be strengthened. The Practice also seeks clarification of Mersey Care's process where a referral or request for expedited assessment is rejected, and the outcome is communicated directly to the patient. This action is referenced in Section 5 point 2 of this response. IV. The Practice has also developed an ADHD referral process during the past year. Following referral, patients receive information and guidance to support them whilst awaiting assessment. As a further action arising from this review, the Practice will enhance this information by including crisis contact details, and clear advice encouraging patients to contact the Practice if their symptoms deteriorate or they require further clinical support whilst awaiting assessment. As the ADHD pathway continues to develop, the Practice will regularly review updated guidance and information from the ICB and other relevant organisations and ensure that information is communicated to patients and communicated practice wide. V. The Primary Care Network (collaborative working of all primary care practice in Runcorn), has recently appointed a Neurodevelopment Practitioner to support patients with ADHD awaiting assessment. A baseline review of patients on the Practice's ADHD waiting list has commenced to identify patients who are still awaiting assessment. The Practice will continue to work with the Neurodevelopment Practitioner and PCN to strengthen patient care, especially of patients awaiting specialist assessment.

5) Follow up appointments were not always offered by GP's at Grove House Medical Practice. In evidence at the inquest, a GP from the practice was unsure if there were NICE guidelines that recommend when GP's should offer follow up appointments after mental health consultations and was not aware if there was a practice policy in relation to follow up appointments after a mental health consultation. I am concerned that there is a risk that mental health is not always monitored so that timely referrals can be made to secondary mental health services.

I. A review of the patient's death was initiated immediately following notification of the death in February 2026, and a Significant Event Analysis was opened as part of the Practice's clinical governance process. The SEA has remained an active, working process throughout the review. Given the severity and circumstances of the event, it was agreed that a further Practice-wide clinical review would take place following the outcome of the Coroner's Inquest. This enabled the Practice to consider the findings of the inquest alongside the learning already identified through the SEA.

II. On 28th July 2026, following the inquest the patient's usual GP presented a detailed chronological review of the patient's care to the Practice's Clinical Governance Meeting, attended by the GP team and Practice Management Team. The purpose of the meeting was to undertake a multidisciplinary review of the clinical management, assess compliance with current guidance, identify learning and agree actions to strengthen future practice.

As part of the review, the patient's clinical history and documented risk assessments was reviewed in-depth. The analysis demonstrated that there was no documented history of suicidal ideation recorded within the patient's medical record. There was one documented episode in February 2026 where thoughts of self-harm were discussed. Alcohol consumption was reviewed during a consultation in November 2025, at which time the patient acknowledged excessive alcohol intake but advised that this had subsequently reduced. Throughout the patient's care, protective factors were identified and documented, including family and children, and the patient had been provided with details of the local Crisis Team. Risk assessments were done at every clinical contact; there was no clinical reason to refer to the crisis team at any point.

The meeting also reviewed the application of relevant NICE guidance relating to the assessment and follow-up of patients presenting with mental health concerns. This guidance was shared with all clinicians as part of the learning arising from the Significant Event Analysis to promote consistency in future practice.

It was noted that although follow-up appointments had been arranged on

	a number of occasions, during the consultation on 3rd February 2026, although the ADHD referral documentation was completed and discussed, a follow-up appointment could have been considered, although this is based on clinical need of the attending clinician. This has been identified as a key learning point, and clinicians have been reminded of the importance of considering and documenting follow-up arrangements based on clinical need. III. The Practice also reviewed the Total Triage model, which has been in place since 2020 and is subject to regular review as part of the Practice's quality improvement programme. The review confirmed that the process worked effectively as intended in this case because when the patient submitted an online consultation, including a completed PHQ-9 questionnaire, the responses of increased clinical risk and in accordance with the Practice's Total Triage process, the request was reviewed by the Duty GP on the same day, and the patient was prioritised for an urgent face-to-face appointment. Although an appointment with the patient's usual GP was not available, the patient was assessed by another GP on the same day. During that consultation, the patient's mental health and suicide risk were assessed, an appropriate management plan was agreed, and safety-netting advice was provided. The Practice considers this to demonstrate that its Total Triage process remains a robust system for identifying and prioritising patients requiring urgent clinical assessment. IV. The Clinical Governance Meeting also identified that there is currently no clearly defined national or local pathway for the management of rejected requests for expedited ADHD assessments where additional clinical information is required. To support clinicians and improve consistency of follow-up, the Practice has agreed to implement the Arden's Depression Review template for patients presenting with depression and mental health concerns. The template incorporates recognised clinical coding, structured risk assessment, documentation prompts and recall functionality, supporting more consistent clinical reviews and follow-up arrangements whilst patients await specialist assessment. V. The Practice will review and strengthen its Did Not Attend (DNA) Policy to ensure a robust and consistent approach to the management of missed appointments. Particular consideration will be given to patients presenting with mental health concerns, including those awaiting specialist ADHD assessment, to ensure appropriate clinical review, timely follow-up and escalation where required. See section 5 point 4. *6) The "Right to Choose" option for an ADHD assessment was not offered until the 3rd February 2026, which was almost 3 years after the initial referral for a diagnostic ADHD assessment. It was known at the time of the initial referral for a diagnostic ADHD assessment, that there were long waiting times for an assessment. I am concerned that there are missed opportunities to request an ADHD diagnostic assessment under*

	the "Right to Choose" option which may enable an earlier assessment I. This issue has been considered in detail through the Practice's Significant Event Analysis. The review recognised that the understanding and use of the Right to Choose pathway has developed considerably since the patient's initial referral in 2023. Since that time, there has been a significant national increase in referrals for ADHD assessment following the COVID-19 pandemic, resulting in substantially longer waiting times. Prior to the SEA review, the Practice had provided education to clinicians regarding the available ADHD referral pathways, including the NHS referred pathway, Right to Choose and private referral options. This reflected the increasing demand for ADHD assessments and the changes taking place within ADHD services. The Practice has also developed an information pack for patients for a Right to Choose referral, providing information to support patients in understanding the available options and making an informed decision about their referral. This work has continued to develop in response to the significant increase in demand for ADHD assessments and the evolving referral pathways. II. The learning from this case was further discussed during the Practice's meeting with Cheshire and Merseyside Integrated Care Board (ICB) on 29th July 2026. The ICB provided information regarding the new Adult ADHD Local Enhanced Service, which will be implemented across Cheshire and Merseyside during 2026/27. The Practice welcomes this development and will continue to engage with the ICB to ensure clinicians have a clear understanding of the evolving ADHD pathway, including the appropriate use of the Right to Choose pathway, local referral options and the support available to patients whilst awaiting assessment. The Practice will also continue to review national guidance and locally commissioned pathways as they develop, ensuring that clinicians remain informed and that patients receive consistent, up-to-date advice regarding ADHD referral options.
5.	DETAILS OF FURTHER ACTION PROPOSED **1) Learning from Patient Safety Events (LFPSE)** The Practice will record this case on the Learning from Patient Safety Events (LFPSE) system to ensure that the learning from this tragic event is shared beyond the Practice and contributes to wider system learning. The intention is to highlight the patient safety risks associated with prolonged waits for ADHD assessment, communication between primary and secondary care, management of patients whose condition deteriorates whilst awaiting assessment, and the importance of robust follow-up and governance processes. **2) Engagement with Mersey Care NHS Foundation Trust** The Practice will formally engage with Mersey Care NHS Foundation Trust to review the circumstances of this case and to seek greater clarity regarding referral pathways, escalation processes and communication between primary

	and secondary care. In particular, the Practice wishes to understand how waiting lists were managed during the transition of the Adult ADHD Service from the former Halton and Knowsley ADHD Service to Mersey Care, including whether there were any changes to referral management, prioritisation processes or communication with referring practices. This will enable the Practice to better understand the patient journey and identify any learning that may improve future referrals and patient support. The Practice is committed to working collaboratively with other organisations to ensure that learning from this case results in meaningful improvements to patient safety and to reduce the likelihood of similar circumstances occurring in the future. **3) Enhancement of patient information and support** The Practice will review and enhance the information provided to patients awaiting ADHD assessment. The existing ADHD patient information welfare pack will be updated to include crisis contact details, information on available support services, and clear advice encouraging patients to contact the Practice if their symptoms deteriorate, they experience a decline in their mental health, or they require further clinical support whilst awaiting specialist assessment. This aims to ensure patients are aware of the support available throughout their waiting period and know how to access timely help should their needs change. **4) Review of the Did Not Attend (DNA) Policy** The Practice will review and strengthen its Did Not Attend (DNA) Policy to ensure a robust and consistent approach to the management of missed appointments. Establishing clear processes for clinical review and follow-up where ongoing clinical risk has been identified and ensuring appropriate documentation and escalation where required. **5) Review of Correspondence Management Policy** The Practice will continue to review of the Correspondence Management Policy in its entirety, initially with the GP Partner then through a Practice-wide review. Following the review, any required changes will be implemented, communicated to all relevant staff and monitored through the Practice's clinical governance and audit processes.
6.	**SIGNATURE**