Coroner inquest into 'hospital non-attendance' management in primary care

In February 2018, our practice came under scrutiny by an inquest regarding the death of a patient who choked to death while detained under section 3 of the Mental Health Act. A year before the fatal event the patient had been referred to speech and language therapy at the local hospital but failed to attend (DNA) the appointment. The coroner considered the possibility of an avoidable death: general practice was expected to follow up the outcome of that referral.[1] Ultimately, general practice is considered to be a safety net for hospital mismanagement and error, and it is expected to assess whether not-attended appointments are still required.

SAFE DNA MANAGEMENT

The practice and the other organisations involved were given time to prepare their cases and, in October 2018, a coroner's inquest took place. It was accepted that the action taken by the practice, inviting the patient for a follow-up with a GP after the DNA letter was received, was a reasonable response. Unfortunately, in the process there was a realisation that not every DNA had a clear recording of a follow-up invitation having occurred. Our current policy had gaps.

Coroners have a role in investigating suspicious deaths, and those that occur while a patient is under custody. If during the course of an inquest the evidence reveals any matters of concern, a coroner's Regulation 28 Report would be triggered, gathering information from the organisation affected so that other deaths can be prevented in the future.[1] The coroner *'may send a copy of the response to any other person who the Chief Coroner believes may find it useful or of interest'*.[2]

MAKING DNA POLICY WATERTIGHT

The organisations and clinicians involved not only have a duty to respond, but doctors are also obliged to inform the GMC without delay if a Regulation 28 Report has been received regarding their performance.[3] The practice discussed this episode as a significant event in February. Two aspects were analysed:

- the need for a better policy to manage hospital DNAs. A policy to contact patients following a DNA was present, although there was no specific requirement for coding or making a clear note on the clinical system of the action taken. A new policy was created that encapsulated these new requirements. Each DNA would be coded, and additional text would explain actions taken; and
- the need for tools to assess the policy implementation. Following policy changes, coding of DNAs would take place, and it would allow running reports and audits, assessing whether DNAs have been followed up and patients invited to discuss the non-attendance. Running these reports on a regular basis could allow for identifying patients marked as DNA and not followed up.

An audit was conducted as part of the preparation for the inquest in October to assess current workflows as they were agreed in February. Among the 8810 patients registered in the practice, 64 were classed as having severe mental illness. Looking at DNAs it was clear that they were happening quite regularly. Over the 3-month period studied (July to September 2018), there were 413 DNAs among our own appointments, and hospital DNAs were in the order of 162.

Focusing on practice DNAs, the non-attendance rate was 4.7%, whether examining the whole registered list or looking at patients with severe mental illness in particular (three cases).

Regarding hospital DNAs, the non-attendance rate was 1.8% for the registered list, whereas for the mental illness population — with five DNAs recorded — it was 7.8%. The difference was statistically significant with a χ^2 statistic of 11.2 ($P<0.05$).

Following the audit findings, it was decided that additional effort should be made to contact those patients who are considered vulnerable or more likely to miss appointments, such as patients with severe mental illness. Contacting the patient by telephone to determine the reason for the failure to attend and, where possible, re-arranging the appointment was agreed. Numbers of cases that would require telephone calls were expected to be quite small, and, in consequence, manageable.

IMPLICATIONS FOR GENERAL PRACTICE

A Spanish proverb states that *'When you see your neighbour's beard cut, put yours to soak.'* The best way to be prepared is to share near misses and to learn from them. Even Regulation 28 Reports to Prevent Future Deaths responses are not easily found,[4] and, in consequence, little learning happens from their occurrence.

To make general practice safer we need to be more open, to share cases such as the one presented here, to keep up the cycle of auditing and reviewing policies, and to be responsive.

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