|  |  |  |
| --- | --- | --- |
| Significant Event (Datix) Alert | | |
| Title: Homicide | | Date: June 2021 |
| The South West and Mid Hampshire part of the system has been receiving Datix Significant Event reports from Primary Care since February 2017. The CCG reviews each Significant Event and shares learning from the key themes and trends identified. This alert highlights key learning relevant to Primary Care following a recent system-wide Significant Event. You are encouraged to review the learning identified from this incident and consider the recommended actions in order to prevent future similar events. | | |
|  |  | |
| Summary | * An learning event was held following a homicide * The patient (P1) was known to mental health services but not under their care at the time * P1s family member contacted the 111 mental health team as P1 had been becoming more unwell during the previous month * P1 was not available to talk to the call handler but ~~his~~ their previous history was noted * Advice given by 111 to contact the GP and call back if more support was needed * P1s family member contacted the practice asking to speak with a GP regarding concerns they had about their family member * The receptionist handling the call~~,~~ stated that they could not connect them with a GP as they had no consent from P1 to do so * However, the family member wished to share information rather than obtain it which would not have been an information governance risk * 6+ weeks later P1 killed someone known to them and later died themselves * The coroner court found no causal link between the contact with the GP practice and the death of the member of the public. | |
|  |  | |
| Identified Risks | * Concerns raised by family members were not documented or escalated to a clinician for review * Discharge summary relating to mental health not reviewed by a clinician | |
|  |  | |
| Identified learning | Following the practices initial investigation and review of the family members phone call a number of concerns were identified:   * the family member was referred back to 111, however they had spoken to them the day before and advised to contact the GP practice * The receptionist disclosed some information to the family member regarding the previous days 111 call * Receiving information from a third party is not an Information Governance (IG) breach * The receptionist did not record and escalate any of the family members concerns to a clinician * The discharge summary from P1s most recent hospital admission was filed rather than being seen and reviewed by a clinician | |
|  |  | |
| Suggested actions | * All mental health related discharge summaries to be sent to the named GP for review * All sign posting conversations to be documented * Training and support to staff members on confidentiality processes and the difference between receiving information regarding an individual from a third party and giving information to a third party * All relevant staff groups should be made aware of the learning from this incident. | |
|  |  | |
| For further information/  support: | WHCCG Primary Care Quality:  Viv O’Connor: [Vivienne.Oconnor@nhs.net](mailto:Vivienne.Oconnor@nhs.net) or Natalie Hallowell: [N.Hallowell@nhs.net](mailto:N.Hallowell@nhs.net) | |