	Senior Coroner, London Inner South, UK Re: Kirabo Kiwanuka, case ref 1556-11 **REGULATION 28 REPORT TO PREVENT FUTURE DEATHS** **THIS REPORT IS BEING SENT TO:** 1. Mr Laurence Mynors-Wallace, Chief Executive Royal College of Psychiatrists Royal College of Psychiatrists 21 Prescott Street London E1 8BB 2. Patricia Wright, Chief Executive Royal College of Physicians 11 St Andrews Place Regent's Park London NW1 4LE
	CORONER I am Andrew Harris, senior coroner for the jurisdiction of London Inner South
2	**CORONER'S LEGAL POWERS** I make this report under paragraph 7, Schedule 5, of the Coroners and Justice Act 2009 and regulations 28 and 29 of the Coroners (Investigations) Regulations 2013.
3	**INVESTIGATION and INQUEST** On 13.02.14, I concluded an inquest into the death of 28 year old Miss Kirabo Kiwanuka, who died on 11th June 2011. The jury found the medical cause of death was sudden unexpected death of a patient with bipolar disorder, treated with multiple drugs. The narrative included this statement: *Due to the complex nature of neuroleptic malignant syndrome, which can be highly atypical, based on the evidence presented we cannot discount or confirm NMS as a contributory factor to Ms Kiwanuka's death.*
4	**CIRCUMSTANCES OF THE DEATH** Ms Kiwanauka was admitted as an emergency on 23.05.11 and as she was a risk to herself and others from her manic behaviour, she was sectioned under the MHA. [redacted] said that her mental state deteriorated, hallucinating, being paranoid and disinhibited. She was treated in secluded confinement, and her parents not permitted to visit for some days. They had concerns about the risks and adverse effects of psychotropic medication. It was reported that Ms Kirawanuka had an episode of illness with pyrexia and tachycardia in 2009, when admitted with mania, following administration of Acuphase. Her creatinine phospokinase was 2215 at the time. She was thought at that time to have a UTI (although the urine test was subsequently sterile), when after transfer to a medical ward, she settled quickly. She also had an idiosyncratic response to Risperidone. On this last admission, she developed a persistent tachycardia. She was begun again on Clopixol Acuphase on 2nd with further injections on 4th and 6th June. She developed a tachypnoea and pyrexia and one of her blood pressure readings showed a drop of 15mm, although there were gaps in recording her vital signs. Her creatinine kinase was 7074 (6041 on repeat) with a raised AST. Clinically she was thought to have a URTI. The psychiatric registrar on call sought advice of a medical registrar on the night before she died, but it was agreed not to transfer her to medical ITU.

	Her psychotropics were stopped and clinically her temperature fell and she was in a coherent state of mind the evening before she died of a cardio-respiratory arrest in her sleep. The expert psychiatrist, [redacted] stated that she had autonomic instability and he could not see how the diagnosis could not be NMS, related to a higher than recommended dose of Promethazine (higher than therapeutic levels at autopsy) and Acuphase. The consultant psychiatrist, [redacted] said it could not be NMS, especially as there was no rigidity. If she thought it was NMS, she had a low threshold for referral. [redacted] said that rigidity was not necessary and it could be masked by the Procyclidine she was taking; [redacted] did not think it could. [redacted] said that the high CK could be due to injections, restraint and mania [redacted] disagreed, saying that a level of CK of 6000 – 7000 could not be caused by these things in the absence of serious injury. He could not explain why cases of NMS had been reported with low CKs. The cardiac pathologist considered sudden cardiac death was likely; the neuropathologist cited the changes in the hippocampal region making an ischaemic injury more likely than hyperthermia. The pathologist who conducted the autopsy was unable to conclude on the balance of probabilities that NMS, oversedation or sudden cardiac death were the cause of death. My expert psychiatrist, [redacted] said that the non referral to a consultant physician at night contributed to her death and that she should have been transferred. NMS has a high mortality up to 33% and required transfer [redacted] my expert consultant in Accident & Emergency did not consider her clinical condition was serious enough to merit transfer to a medical ward, judging there not to be autonomic instability, exemplified by non variation in diastolic blood pressure. [redacted] said that psychiatrists were more experienced than physicians in managing NMS. She expressed reservations and concerns about the safety of transferring someone so sick. A health care assistant expressed the view that the local medical wards could not handle acutely disturbed patients. [redacted] said that medical teams look after delirium and should have looked after Ms Kiwanuka. [redacted] did not think that not transferring to a medical ward contributed to death, even though it was acknowledged that she would receive intensive monitoring. She was not examined by a physician when she developed abnormal vital signs. At the time it appears that there was no facility for a physician from the neighbouring hospital to be called out for a medical opinion, although this is currently being explored by SLAM and King's College Hospital.
5	**CORONER'S CONCERNS** During the course of the inquest the evidence revealed matters giving rise to concern. **MATTERS OF CONCERN** are as follows. **The diagnosis of NMS has a mortality as much as 36%, but there appears to be great uncertainty about diagnosis and management:** **1. There is lack of senior professional agreement about the criteria needed for diagnosis of NMS, or the need for referral to physicians, even in retrospect** Doctors did not agree whether atypical NMS exists and whether in the absence of rigidity cases should be managed differently. In particular a psychiatrist considered psychiatrists were better at care of NMS in their ITU, despite there not being facilities for cardiac monitoring or frequent blood gas analysis, as recommended by the expert psychiatrist, whilst my expert physician simply did not think she needed intensive medical care. There was even disagreement whether a medical registrar opinion or consultant was required. How are junior staff to know what is optimal care?

2. There is lack of clarity about whether acutely manic patients in a psychiatric facility with physical illness should receive domiciliary visits from physicians and medical care in the psychiatric facility or be transferred to a medical facility, where psychiatric staff attend and visit.

She was not examined by a physician when she developed abnormal vital signs. At the time it appears that there was no facility for a physician from the neighbouring hospital to be called out for a medical opinion, although this is currently being explored by SLAM and KCH and is included in a draft protocol. When are patients best under the care of a medical and when a psychiatric ITU? How are Trusts to know what is the optimal model of care?

3. Where a patient lacks capacity and is under section, the involvement of the family in determining her best interests is required but here it was limited and yet they had concerns about the risks of treatment.

The parents were not given the opportunity to contribute their views to the decision to administer Acuphase, but decisions had to be taken in situations of acute disturbance. What is the role of each of psychiatrists, physicians and next of kin in reaching critical care decisions for sectioned patients with acute medial and psychiatric problems?

6

ACTION SHOULD BE TAKEN

In my opinion action should be taken to prevent future deaths. The Royal Colleges of Psychiatrists and Physicians are asked to consider the concerns arising from this case and whether, as recommended by my expert psychiatrist, there needs to be joint College guidance on management of acute physical health problems of manic or psychotic patients at risk of sudden death.

7

YOUR RESPONSE

You are under a duty to respond to this report within 56 days of the date of this report, namely by Friday April 25th 2014. I, the coroner, may extend the period.

Your response must contain details of action taken or proposed to be taken, setting out the timetable for action. Otherwise you must explain why no action is proposed.

8

COPIES and PUBLICATION

I have sent a copy of my report to the Chief Coroner and to the Interested Persons:
[redacted] Leigh Day for [redacted]
[redacted], Bevan Brittan for SLAM Trust
I have also sent it to [redacted]

I am also under a duty to send the Chief Coroner a copy of your response. The Chief Coroner may publish either or both in a complete or redacted or summary form. He may send a copy of this report to any person who he believes may find it useful or of interest. You may make representations to me, the coroner, at the time of your response, about the release or the publication of your response by the Chief Coroner.

If you would like further information about the case, please contact my officer, [redacted]

9

[DATE] 3rd March 2014 **[SIGNED BY CORONER]**