REGULATION 28: REPORT TO PREVENT FUTURE DEATHS (1)

*NOTE: This form is to be used **after** an inquest.*

	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO:** **1.** Mr Jeremy Hunt, Secretary of State for Health
1	**CORONER** I am Kevin McLoughlin, HM Assistant Coroner , for the Coroner Area of Manchester West
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 20th January 2011 an investigation was commenced into the death of Daniel Joseph McCallum Keane, aged 32. The investigation concluded at the end of an Article 2 compliant inquest on 9th June 2014. The cause of death was found to be 1a) Ketoacidosis. A narrative conclusion was recorded, (a copy of which is attached). The key features of the narrative were: The following aspects of the management of Daniel's treatment and care made more than a minimal contribution to his death: 1. A lack of leadership in the management of his case. Daniel's complex medical and social needs crossed boundaries between different medical specialties, NHS Trusts, in patient and community based teams, primary care providers and social care agencies. No-one with appropriate authority took responsibility for the active co-ordination of the multiple disciplines involved. 2. The absence of a clear plan to deal with the situation that existed in the months after Daniel had self discharged from hospital, first on 9 September but again on 27 September 2010. 3. Ineffective multi-disciplinary meetings (MDTs) took place on or about 24 September and 17 November 2010. Key participants were not in attendance at the former. At both it was unclear who was in control of his case or responsible for the production of an action plan with assigned tasks and a timetable stipulating by when reports on progress were

	required. The fact that some of those attending did not receive the minutes reflects the lack of clarity and direction at those meetings. Without effective management, matters drifted in the 8 week period between the last MDT and Daniel's death on 14 January 2011. 4. The absence of a clear role for the General Practitioner once Daniel had left hospital. The GP had never seen Daniel even though he was a patient with complex needs and had been registered with the GP's practice since 19 October 2009. Confusion over the GPs role led to: (a) The prescription of citalopram on Wednesday 29 September 2010. This occurred just after Daniel self discharged from hospital, against medical advice. He had not been prescribed citalopram for some months beforehand whilst in hospital, albeit that suicidal ideation had been suspected on occasions in and after 2009. It is unclear why citalopram was commenced on 29 September 2010, who deemed it necessary nor what features of Daniel's presentation at that time justified the prescription. No action was taken to review this prescription or follow up his condition subsequently. (b) the GP not being invited to either MDT meetings, nor furnished with a copy of the minutes of the MDT on 17 November 2010. (c) the GP being telephoned on 8 November 2010 by a clinician who voiced her concerns over Daniel's wellbeing, and asked for an urgent referral to the district nurses. The GP indicated that he could not refer to district nurses. No action was taken by the GP in response to this alert.
4	**CIRCUMSTANCES OF THE DEATH** On 1th January 2011, Daniel Keane was found dead at his home. The post mortem revealed the cause of death to be Ketoacidosis. Daniel Keane was a Type I diabetic with frontal lobe brain damage sustained following a diabetic coma in November 2009. His memory and executive functioning were impaired. Daniel Keane has been treated in a variety of hospitals and other institutions during 2010. He had undergone neuro-rehabilitation but had failed to engage with the programme. He had been compulsorily detained under the Mental Health Act in February 2010 and had been subject to a Deprivation of Liberty Order for 7 days in August 2010. On occasions he refused insulin and food. On 9th September 2010 he self discharged from hospital and returned to live on his own without effective support (save from his family). Within 5 days he had to be admitted to the Intensive Care Unit of Salford Royal Hospital after being found in an unresponsive condition at his home. He was not reliable in the management of his diabetic regime. On 27th September 2010 he again self discharged. At this point the clinicians involved in his care did not consider he had capacity to make decisions

	concerning the management of his insulin therapy or diet (within the meaning of the Mental Capacity Act 2005). At Multi-Disciplinary Meetings (MDT's) on 24 September 2010 and 17th November 2010 it was agreed he needed a support package to supervise his adherence to the essential insulin therapy. Daniel Keane refused help from the district nurses who attended his home after he left hospital. He failed to attend a diabetic clinic appointment on 5th November 2010. In the 3½ months between his self-discharge from hospital and his death, he was left without active support, except for that provided by his family. Daniel Keane had registered with a GP, [redacted] on 19th October 2009, but had never been seen by his GP. On 29th September 2010 his GP prescribed citalopram even though he had not been on this medication whilst in hospital for some months. It is not clear why citalopram was indicated or who judged it was appropriate to do so, as he was not seen by his GP (a sole practitioner).
5	**CORONER'S CONCERNS** During the course of the inquest the evidence revealed matters giving rise to concern. In my opinion there is a risk that future deaths will occur unless action is taken. In the circumstances it is my statutory duty to report to you. The **MATTERS OF CONCERN** are as follows: [redacted] was called to give evidence at the Inquest. He accepted in the course of his evidence that his record keeping was inadequate. He could not say from either his records or his recollection who had arranged for diabetic medication or citalopram to be prescribed or 29th September 2010. [redacted] had no recollection or contemporaneous record of a telephone conversation with a neuropsychologist called [redacted] on 8th November 2010 in which she said she alerted [redacted] to Daniel Keane's situation, which she described to him and indicated it was very worrying. [redacted] asked him to make an urgent referral to the district nurses as she was concerned he was not reliable in managing his insulin himself. [redacted] said he could not refer to the district nurses. Despite having been put on alert in this telephone conversation [redacted] took no action. At this time [redacted] was in possession of various reports including a Multi-Disciplinary Team Discharge Summary dated 2nd September 2010 that concluded Daniel Keane was at extreme risk to himself and was not a safe option to live by himself without supervision. The action I consider should be taken includes: 1. A review of record keeping practices within [redacted] practice.

	2. An investigation of the circumstances in which citalopram was prescribed on 29th September 2010 to establish who deemed this medication necessary, what features of his presentation justified this medication and the follow up action envisaged. 3. An investigation into [redacted]'s lack of response to the telephone conversation with [redacted] on 8th November 2010. 4. Consideration of the role of GP's generally in relation to the management of Type 1 diabetic patients in the community.
6	**ACTION SHOULD BE TAKEN** In my opinion urgent action should be taken to prevent future deaths and I believe your department have the power to take such action.
7	**YOUR RESPONSE** You are under a duty to respond to this report within 56 days of the date of this report, namely by Wednesday 30th July 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 following Interested Persons: 1. The family of Mr Daniel Joseph McCallum Keane 2. Salford City Council. For the attention of [redacted] 3. Salford Royal NHS Foundation Trust. For the attention of [redacted] 4. Greater Manchester West Mental Health NHS Foundation Trust 5. [redacted] RadcliffeLeBrasseur for [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.
9	**Dated** **9th June 2014**
	Signed Kevin McLoughlin **Kevin McLoughlin**