ANNEX A

## REGULATION 28: REPORT TO PREVENT FUTURE DEATHS (1)

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

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| | **REGULATION 28 REPORT TO PREVENT FUTURE DEATHS**<br><br>**THIS REPORT IS BEING SENT TO:**<br><br>1. **Cricket Green Medical Practice**<br>**75-79 Miles Road**<br>**Mitcham**<br>**Surrey**<br>**CR4 3DA**<br><br>2. **David Bradley, Chief Executive**<br>**South West London & St George's Mental Health NHS Trust**<br>**Springfield University Hospital**<br>**Building 15, 2nd Floor**<br>**61 Glenburnie Road**<br>**London**<br>**SW17 7DJ**<br><br>3. **Rt Hon Jeremy Hunt MP**<br>**Secretary of State for Health**<br>**Department of Health**<br>**Richmond House**<br>**79 Whitehall**<br>**London**<br>**SW1A 2NS** |
| 1 | **CORONER**<br><br>I am ANGELA HODES, assistant coroner, for the coroner area of LONDON, INNER WEST |
| 2 | **CORONER'S LEGAL POWERS**<br><br>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**<br><br>On 24 MARCH 2017, an investigation was commenced into the death of GILLIAN O'KEEFE, AGED 50 YEARS OLD The investigation concluded at the end of the inquest on 5 SEPTEMBER 2017.<br><br>The conclusions of the inquest were as follows:<br><br>***Medical cause of death*:**<br><br>**Quetiapine consumption**<br><br>***How, when and where Mrs O'Keeffe came by her death:***<br><br>**On 19 March 2017 Mrs O'Keefe was found dead in her home. She suffered from a schizoaffective disorder and had been prescribed Quetiapine. Attempts to invite her to re-engage with community mental health services had failed.** |

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| | *The conclusion of the Coroner as to the death:*<br><br>**Mrs O'Keeffe took her own life whilst the balance of her mind was disturbed** |
| 4 | **CIRCUMSTANCES OF THE DEATH**<br><br>(i) Mrs O'Keeffe had a serious mental illness and was coded as a vulnerable adult on her notes at her local GP surgery.<br>(ii) Mrs O'Keeffe was under the care of the Mitcham Recovery and Support Team and was seen by them on a regular, often monthly basis, throughout 2014 and 2015;<br>(iii) Her mental state deteriorated and she was referred to Merton Home Treatment team from March –May 2016 and prescribed supervised antipsychotic medication. When her mental health appeared improved she was discharged back to the care of Merton Adult Mental Health Services (Wilson Hospital, Cranmer Road Mitcham) in May 2016 and allocated a new care co-ordinator.<br>(iv) Mrs O'Keeffe was last seen at her GP practice, on 8 June 2016 for a medical check-up and at that time she felt well.<br>(v) On 24 October 2016 Mrs O'Keeffe's sister raised concerns about her and an ambulance was sent to check on her. She was not seen but reviewed by her care coordinator on 31 October 2016 and found to be stable in her mental state and confirmed her compliance with medication.<br>(vi) Mrs O'Keefe did not respond to any appointments offered by the Merton Adult Mental Health Services in November, December or January and so she was discharged from the team due to *non-engagement*; she was offered to self-refer or ask her GP to refer her back if needed in the future.<br>(vii) Her sister gave evidence that the 'system' made it difficult/ impossible for information from the family to be shared and acted on by Mrs O'Keeffe's medical team and therefore she did not consider that her sister was supported appropriately by the mental health team.<br>(viii) Mrs O'Keefe's GP received the notice of her discharge in January 2017, that Mrs O'Keeffe had been returned to her care without any planning or prior notification to the GP.<br>(ix) The GP's surgery was unable to make contact with Mrs O'Keeffe in January or February 2017, notwithstanding that they had raised their concerns at a practice meeting with the CMHT, nothing had been done and on 15 March 2017 the GP wrote a referral to the CMHT as she remained concerned about Mrs O'Keeffe's summary discharge from mental health services. |
| 1 | **CORONER'S CONCERNS**<br><br>During the course of the inquest the evidence revealed matters giving rise to concern. In my opinion there is a risk that future deaths could occur unless action is taken. In the circumstances it is my statutory duty to report to you.<br><br>The **MATTERS OF CONCERN** are as follows. –<br><br>(1) That the decision to discharge Mrs O'Keeffe '*for non-engagement*' from the local Mental Health NHS Foundation Trust care in January 2017 appeared illogical when it was likely, having regard to the facts, that she was in greatest need of their help: she was a service user of long standing, she had an acute deterioration in her mental state in March 2016, that there had been concerns raised by her family in October 2016 and that no professionals had been able to make visual contact with her since October 2016.<br>(2) In view of her history and the inability of the Trust or GP surgery to make contact with Mrs O'Keeffe it was highly unlikely that she would self-refer.<br>(3) There was no pre-discharge multidisciplinary meeting to include and inform the GP before discharge nor attempt to ensure that there was a seamless transition to the GP surgery.<br>(4) Evidence was given at the inquest that there was no procedure or policy in place at the Trust to follow up GP concerns or referrals particularly where there was likely to be a degree of urgency.<br>(5) There appeared no easy or appropriate way that the family were able to share information and their concerns about Mrs O'Keeffe's mental health with the professional team, consequently, notwithstanding the family's continual and concerted attempts to notify Mrs O'Keeffe's care co-ordinator, they felt that the |

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| | professionals were unaware of the parlous state of Mrs O'Keeffe's mental health and the family's serious concerns. |
| 6 | **ACTION SHOULD BE TAKEN**<br><br>In my opinion action should be taken to prevent future deaths and I believe you [AND/OR your organisation] have the power to take such action. |
| 7 | **YOUR RESPONSE**<br><br>You are under a duty to respond to this report within 56 days of the date of this report, namely by 24th November 2017. I, the coroner, may extend the period.<br><br>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**<br><br>I have sent a copy of my report to the Chief Coroner and to the following Interested Persons:<br><br>(i) [redacted]<br><br>(ii) [redacted]<br><br>I am also under a duty to send the Chief Coroner a copy of your response.<br><br>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 | **28th September 2017**<br><br>Angela Hodes<br><br>**Angela Hodes**<br>**Assistant Coroner**<br>**Inner West London** |