REGULATION 28: REPORT TO PREVENT FUTURE DEATHS

This report is made under paragraph 7, Schedule 5, of the Coroners and Justice Act 2009 and regulations 28 and 29 of the Coroners (Investigations) Regulations 2013.

Recipients

This report is being sent to:

- Ms Joanne Roney – Chief Executive, Manchester City Council (MCC)
- [redacted] – City Solicitor, MCC
- Dr Chris Daly – Medical Director, Greater Manchester Mental Health NHS Trust

Coroner

I am Nigel Meadows, HM Senior Coroner for the area of Manchester City.

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.

Investigation and Inquest

On 21 November 2017 I commenced an investigation into the death of Janice Andrea Keelan, aged 48. The investigation concluded at the end of the inquest on 14 February 2018.

The cause of death was found to be:

1a Drowning

The conclusion of the inquest was Accidental Death.

Circumstances of death

The deceased was a 48 year old single person who suffered from chronic and complex health conditions. She had been diagnosed over a long period of time with a variety of conditions including schizophrenia; affective psychosis; schizoaffective disorder recurrence in puerperium; paranoid depression; bipolar affective disorder and Korsakoff's syndrome.

Her most recent medications were Depakote in tablet form; Risperidone in tablet form, Promethazine in tablet form and Risperidone Conta administered as a fortnightly depot injection.

Toxicology tests showed that she had not consumed alcohol or taken an overdose of her medications, and only a small amount of Promethazine was detected which was consistent with therapeutic use. There were no traces of her antipsychotic medications and this may indicate that she had not recently taken these in tablet form and that she was due to have a further injection of her depot medication.

She lived at [redacted] with her adult daughter, who was acting as her primary carer. She died on 14 November 2017.

In the days before she died, her daughter noticed a deterioration in her mental state and she seemed to be responding potentially to auditory and visual hallucinations. From the beginning of the year, her daughter had noticed that on occasions she would fall asleep in the bath. The deceased's medication also had the effect of making her sleepy or drowsy. The nature of her mental health disorders meant that she was prone to relapses which occurred not infrequently. Her daughter was concerned that her mother could possibly fall asleep in her bath and drown.

It was reported that in June 2017 she suffered a witnessed seizure and was admitted to hospital. No treatment was required and she was discharged back to her GP, who reviewed her in July and actually considered the event in the bath was likely to be a vasovagal episode. Nonetheless, she was referred to the First Fit clinic but did not attend.

As a consequence of the deceased's daughter's concerns for her mother's welfare in the bath, a referral was made to MCC in order for her bath to be removed and replaced with a walk-in shower. The referral was received, it seems, in May or June 2017, but was allocated to a primary assessment officer on 7 July 2017, who attended the deceased's home on 21 July 2017. This visit coincided with the attendance of a Community Psychiatric Nurse (CPN) in order to administer the deceased's regular injection of antipsychotic medication. Her daughter was also present.

The CPN told the MCC assessor that she was concerned that the deceased has recently scalded herself in the bath and has recently experienced seizures. Her daughter also reported that the deceased's 'medication makes her drowsy and she has found her asleep in the bath on several occasions and she is frightened that her mum will drown'. The

assessor records in the assessment document: 'I have advised she does not use the bath and I will make a referral to MSIL to request a walk-in shower assessment.'

The assessment was then passed on to the assessment team manager for progression. By 11 August 2017, an advanced assessment officer had visited the deceased and confirmed she met the eligibility criteria for the bath to be removed and for a wet room/shower to be installed. The assessment team manager authorised the assessment and sent it on 25 August 2017 to the 'Major Panel'. In practical terms, this resulted in her referring the matter to herself, because she was the sole member of 'the Panel'. This triggered an MCC technical team assessment, which was allocated to a technical officer on 6 October 2017 and finally approved on 24 November 2017, ten days after the deceased died.

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.

1. It must have been apparent that the deceased suffered from fluctuating and impaired cognition and probably lacked 'mental capacity' to make decisions about her own care and welfare. The initial assessment on 21 July 2017 clearly demonstrated that she was at significant risk of having an event when using the bath which could prove fatal. Suggesting to a person with the deceased's mental health conditions that they should not use the bath is completely unrealistic. Her daughter had been struggling to cope with her mother over some years. No apparent thought was given to obtaining authority from the deceased to obtain information from the mental health team to give a fuller picture and a more detailed explanation of the effects of her medication. This also could have produced evidence as to the manifestation of her psychiatric conditions and how, for example, she might have felt the bath was a safe place and a sanctuary from recurring symptoms There was also clear evidence that the deceased had scalded herself in the bath. She may not have appreciated how hot the water was and people can and do die from scalding burn injuries when using a bath. This added to the risks to the deceased.

2. It was understood that there was some form of prioritisation process for dealing with these sort of cases, although it was not entirely clear at the inquest hearing how this actually worked, specifically and in detail in practice. The process in this case clearly required urgent prioritisation because of the obvious and apparent risk of death, which MCC were told about at the outset.

3. It does not appear that following the death of the deceased, there has been any internal review or reflection by MCC about the processes involved in this case, or the need to address changes to the prioritisation criteria.

4. The death was potentially avoidable. If for practical reasons the work simply could not have been done prior to 14 November 2017, contact could have been made with the mental health team seeking assistance and advising them of the position so that

they could take steps to intervene in order to minimise the risk of a fatality. Sadly, the deceased died just as her daughter feared she might and that is why the application had been made in the first place

Action should be taken

In my opinion action should be taken to prevent future deaths and I believe your organisation has the power to take such action.

1. The above four numbered paragraphs set out the issues which need to be addressed

Your response

You are under a duty to respond to this report within 56 days of the date of this report, namely by 16 April 2019 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.

Copies and publication

I have sent a copy of my report to the Chief Coroner and to the following Interested Persons:

- The deceased's daughter
- The deceased's sister
- The deceased's niece

I am also sending a copy to the Medical Director of the Mental Health Trust.

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.

N Meadows **19 February 2019**
H.M. Senior Coroner – Manchester City area