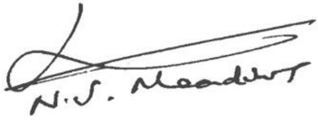
REGULATION 28: REPORT TO PREVENT FUTURE DEATHS.

	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO:** • Dr [redacted], • Medical Director • Greater Manchester Mental Health NHS Trust (GMMH) • Trust HQ, • Prestwich Hospital, • Bury New Road, • Manchester • M25 3BL • Copied for interest to: • [redacted] – the deceased's sister • [redacted] – the deceased's sister • [redacted] – the deceased's brother • The Care Quality Commission • Manchester MHCC • Professor [redacted] – the Diabetes Centre – MFT NHS Trust • Professor [redacted] – Salford Royal Hospital -Diabetes Centre • Dr. [redacted] GP – Chorlton family Practice • Manchester Local GP Medical Committee
1	**CORONER** I am: Senior Coroner Nigel Meadows Senior Coroner for Manchester City Area HM Coroner's Court and Office Exchange Floor The Royal Exchange Building Cross Street Manchester M2 7EF
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 the 23/05/19 I commenced an investigation into the death of Jude Daryl Lloyd. The investigation concluded on the 30th September 2021.

	The Conclusion of the inquest was**: Natural Causes contributed to by Neglect**
4	**CIRCUMSTANCES OF THE DEATH** The court heard evidence that Mr. Lloyd suffered from a chronic Schizo-Affective disorder and been taking antipsychotic medication for several years. He also suffered from Diabetes Mellitus and was being prescribed medication for this. He had a history of non-compliance with medication and disengagement with services as well as previous compulsory admissions under the MHA. He was arrested by the police but was taken to A&E on the 3rd January 2019 after having suffered a serious deterioration in his mental state. In addition, he was also diagnosed as suffering from abnormal blood glucose levels and demonstrated very poor diabetic control. He was detained under S. 2 MHA on the 5th January 2019 at the Meadowbrook Psychiatric Unit in Salford but was subsequently detained under S.3 of the MHA at the same unit. During the course of the admission he refused to take his diabetic medication or agree to blood sugar testing. He denied having Diabetes or mental health problems. He was “insightless” and was considered to lack capacity to make informed decisions about his healthcare. No formal mental capacity assessment was undertaken or recorded. It was thought that he might have been suffering from Diabetic Ketoacidosis which is a life-threatening condition. It was recognised that he did need diabetic care review. Since he was not an in-patient at Salford Royal Foundation NHS Trust (SRH) or registered with a GP in the Salford area he could not be seen by the specialist diabetic team at SRH but other options of referral from his own GP and the Manchester Diabetes Centre were not pursued. Insufficient and inadequate efforts were made to contact his family members who could have assisted in communication and persuasion to accept medication and advice. Overall medical record keeping was poor or absent in several instances. Early in the admission the results of a HBA1c test was 135 which is grossly abnormal. Despite the treating team being aware of a history of high HBA1c there was no contact made with the GP about this and no plan formulated and implemented to deal with the associated risks. Despite his HBA1c there was no recognition that his physical health may be impacting on his mental health. He began to accept his antipsychotic medication and but was discharged on the 22nd February 2019 under a Community Treatment Order (CTO) into the care of the Community Health Treatment Team (CMHT). Despite it being recognised that he presented a serious risk of no-compliance on discharge there was not an appropriate care plan involving the CMHT , the GP and a hospital Diabetes centre. The transfer of care to the CMHT was not appropriately managed. There was also a lack of clinical review and leadership from the CMHT Responsible Clinician (RC). There was no evidence that the possible effect of his antipsychotic

	medication may have had on his blood glucose was considered or reviewed. There was no clear recognition that his insight into his diabetes may have changed since he became mentally unwell. No regular checks were made to ascertain if he was still obtaining his diabetes medication. In April the deceased was complaining of side effects, but no consideration was given to the risk and likelihood that these may be associated with his diabetes. On the 18th April 2019 when receiving his depot medication he agreed for blood samples to be taken. When analysed this showed an abnormal HBA1c of 108. This was not appropriately recorded but only referenced in May 2019 when the deceased was not answering phone calls. He was found dead on the 8th of May at his home address and died because of Diabetic Ketoacidosis. It was only discovered after his death that he had not collected his GP prescribed Diabetes medication from the 16th March 2019. The GMMH internal post death investigation was incomplete in several aspects. The CMHH RC did not provide statement and nor was he interviewed to establish his knowledge and involvement in the discharge planning and ongoing management to explain the rationale for his clinical decisions.
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: 1. a. No thorough comprehensive risk review and care plan was formulated in relation to his Diabetes monitoring and management prior to his discharge from the inpatient unit. This was not recognised before he left the ward and it was not discovered by the CMHT when they took over his care. b. No appropriate formal mental capacity assessments were made and properly recorded although this would also be relevant in managing his mental and physical conditions. c. The transfer and communication process from inpatient care to the CMHT was inadequate and incomplete. d. No appropriate contacts were made with the GP whilst the deceased was an in-patient to obtain relevant clinical information to assist in managing a serious physical health condition with potentially life threating complications and assist in the discharge planning. Nor were regular appropriate contacts made with the GP after discharge which would have highlighted the absence of medical management for a serious physical health condition.

	e. Whilst a psychiatric inpatient and suffering from a serious physical health condition which requires monitoring and treatment it was not possible to obtain appropriate specialist advice because the deceased was not an inpatient in hospital and was not registered with a GP in that area. Consequently, there was a gap in care provision which requires local NHS primary and secondary care procedural review to resolve. f. Despite complaining of side effects, there was no apparent awareness of or consideration given to the risk and likelihood that these may be associated with his diabetes. No appropriate clinical advice was sought. g. There were a number of missed opportunities for the CMHT to assess changes in his presentation and risk profile due to a lack of appropriate communication between mental health and primary care professionals. h. There was no robust audit system for checking compliance with the Trusts own policies and protocols in particular with regard to medical record keeping, risk assessments and reviews. h. The GMMH SUI investigation report contained several factual errors and misinterpretations. The CMHT Responsible Clinician did not provide a statement or was interviewed despite him being a crucial witness. This meant the all the lessons for future care and planning were not learnt. There was inadequate overview of the report before it was signed off.
6	**ACTION SHOULD BE TAKEN** In my opinion action should be taken to prevent future deaths and I believe you and your organisation 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 the 6th December 2021. 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 Interested Persons. I have also sent it to organisations who may find it useful or of interest. 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	**DATE: 4th October 2021** **Mr Nigel Meadows** HM Senior Coroner Manchester City Area

	 **Signed:**