From the Rt Hon the Earl Howe P.C.
Parliamentary Under Secretary of State for Quality (Lords)

Department of Health

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Mr K McLoughlin
Assistant Coroner
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03 JUL 2014

Dear Mr. McLoughlin,

Thank you for your letter following the inquest into the death of Daniel Keane. In your report you conclude that the cause of death was Ketoacidosis. I was sorry to read of the events that led to Daniel's death and wish to extend my sincere sympathies to his family.

You are concerned that several aspects of the management of Daniel's treatment and care made more than a minimal contribution to his death. These included:

- Lack of leadership in the management of Daniel's case;
- The absence of a clear plan to help Daniel after he twice self-discharged from hospital;
- Ineffective multi-disciplinary team (MDT) meetings with no-one taking overall control or being responsible for producing an action plan. There was a lack of clarity and direction at the meetings;
- Absence of a clear role for the GP once Daniel had left hospital;
- The GP prescribing Citalopram even though Daniel had not been prescribed this for some months beforehand whilst in hospital. The GP took no action to review this prescription or follow up on Daniel's condition subsequently;
- The GP not being invited to MDT meetings or provided with copies of any minutes;
- The GP not taking any action in response to an alert about Daniel's situation and well-being from a clinical neuropsychologist;
- Inadequate record keeping by the GP – he could find no records of who had arranged for Citalopram to be prescribed, or of the telephone conversation with the neuropsychologist.

You consider that the following actions should be taken:

- A review of record keeping at [redacted] practice
- An investigation of the circumstances in which Citalopram was

prescribed and the follow up action envisaged

- An investigation into [redacted] lack of response to the telephone conversation with the neuropsychologist, [redacted]
- Consideration of the role of GPs generally in relation to the management of Type 1 diabetic patients in the community.

I consider that the first three concerns, relating to [redacted] should be raised with the General Medical Council (GMC) and the Care Quality Commission (CQC). To this end, my officials contacted your office on 12 June to advise that these actions would be most appropriately addressed by the GMC and CQC. We suggested that you write to both these organisations for their separate responses to these issues. These organisations have the power to take action where warranted.

You also note that there was an absence of a clear plan across primary, secondary and community care, and absence of a clear role for the GP, to help manage the situation in the months following Daniel's self-discharge from hospital. I recognise that there is sometimes potential for transfers of care to fail. This concern is currently being addressed by the patient safety expert group (primary care) at NHS England. This group is undertaking work on safer discharge from hospital.

With regard to your fourth point, that consideration be given to the role of GPs in managing Type 1 diabetic patients in the community, you will be aware that this is a complex issue. GPs play an important role in the management of many long-term health conditions in the community. NHS England, the organisation responsible for commissioning primary care services, is currently considering the long-term implications of developing this role.

I hope that this response is helpful and I am grateful to you for bringing the circumstances of Daniel Keane's death to my attention.

Yours sincerely,

Earl Howe

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