Royal College of General Practitioners

Dr Jamie Hynes FRCGP
Vice Chair Member Standards

Miss Sarah Wood
Assistant Coroner for the coroner area of Nottinghamshire

[redacted]

6 January 2026

Dear Miss Wood

Regulation 28 Report to Prevent Future Deaths - regarding the death of Mr Gunaratnam Kannan

Thank you for asking us to comment on the matters of concern following the sad death of Mr Gunaratnam Kannan who died on the 19th of March 2025. Apologies that there has been a delay in response as the notification was received by my predecessor and came to my attention after my appointment to this role in December. Our sincere condolences go to his family and friends given the difficult circumstances and the ongoing questions on how this could have been prevented. We will address the issues raised as requested in the hope that the response can help answer the concerns of the Coroner and Mr Kannan's loved ones.

You have two matters of concern relating to this tragic death.

- Lack of joint agency working/policy work on the Mental Capacity Act Assessments and Mental Health Act Assessments setting out the roles and remit of service providers.

- Lack of training of service providers on the Mental Capacity Act assessments and the process for referrals for Mental Health Act assessments.

To give context to the family, The Royal College of General Practitioners works to improve patient care by encouraging the highest possible standards in general medical practice by supporting members, setting standards, providing education and training, promoting research and advocating and representing the College and its 56,000 members.

General Practitioners have a broad curriculum, and the College is responsible for the definitive educational framework for all doctors undertaking GP speciality training. There are 5 areas of capability aligned to the General Medical Council's Generic Professional Capabilities Framework, and these are supported by twenty-two Clinical Topic Guides. The

area of Mental Health Act assessment is covered in the Mental Health Clinical Topic guide and in this case the two areas of a GP's role relates to:

- coordinate care with other organisations and professionals (for example, ambulance service, community mental health teams, social workers, secondary care, voluntary and community sectors, social prescribers and police)

- follow agreed protocols, including as part of the Mental Health Act and the Mental Capacity Act where appropriate.

Service issues are also covered during GP Training within the urgent and unscheduled care topic with 'Dangerous Diagnoses' being outlined, such as suicide risk, mental health crisis and the importance of communication with emergency services. Strategies for ensuring effective and appropriate communication and escalation of care to other service providers are also covered.

As well as the GP curriculum, the RCGP makes available a Mental Health toolkit for our members which includes an area on Crisis, self-harm, and suicide with links to the NICE guideline CG136 with recommendations relevant to this case and the Mental Health Act.

Although the RCGP does not have a role in the regulation of General Practice service provision, the regulator CQC has made specific reference to areas of mandatory training considerations in General Practice (GP myth buster 70) . This specifically mentions that they expect to see evidence of training for Mental Capacity Act and Deprivation of Liberty Safeguards from GP Service providers, which have relevance to the challenging scenario facing professionals and Mr Kannan's family. Training is provided via external sources, for example e-Learning for Health, CPD UK and other platforms.

Re-examining specific issues of Mr Kannan's case is beyond the remit of the College, but it highlights the need for Nottinghamshire HCT to reassert their processes of acceptable medical practitioners instigating urgent referrals to enable best outcomes and prevent future deaths in similar circumstances.

Having reviewed the Nottinghamshire Healthcare NHS Foundation Trust mental Health legislation (MHL) Policy and Procedure manual, we believe that more clarity on the policy is required and further training opportunities for Nottinghamshire Healthcare NHS Foundation Trust staff. We have concerns around the lack of priority given to urgent mental health services and for individuals with serious mental health concerns to receive timely and effective crisis management. Mental health teams, often within a single Mental Health Trust, need to be integrated to support a personalised care approach. It would be worth NHS England considering how mental health providers commission services to enable this to be developed in all policy and procedures for NHS Mental Health Trusts. We hope that the reflective processes are in place to ensure such a difficult outcome would not be repeated if a similar scenario for other patients developed in future.

We recognise that there is also an issue around communication between the GP and the paramedic who attended initially. There would be a significant difference in response between an overdose of [redacted] Metformin and [redacted] Metformin. The current toxbase advice would suggest that ingestion of [redacted] or more metformin should be referred for medical assessment. For a 70kg man this would equate to a threshold of [redacted] tablets of metformin (the quantity of [redacted] tablets is well above this threshold). The peak levels are reached after around 7 hrs of ingestion, and this then increases the metabolic consequences of lactic acidosis and death. The ingestion of [redacted] tablets of indapamide tablets would have also been a toxic dose (above the threshold of [redacted]) further increasing the risk of harm and toxicity to the patient. Clear risk as suggested by the paramedic was identifiable from either of the medications taken in overdose.

System pressures create decision making risks and GPs are taking on more work due to these pressures, with increasing numbers of ambulance paramedic calls supporting patients to remain in the community wherever possible. It is important to recognise that GPs require dedicated time, resources and connected clinical systems to support decision making, especially where the decision making is complex and involves multiple agencies. Many of these calls are made whilst GPs are performing other patient-facing and administrative duties. As such, this risks impacting on effective communication between professionals. There is an opportunity to address the System aspects of the referral processes, to alleviate the workload pressures sufficiently to best serve the complex decision-making GPs engage in, in the hope of preventing future deaths in similar circumstances.

Once again, our condolences go to Mr Kannan's family and friends, and we thank you for extending the date for this response to reach you. I hope the comments provide a full picture of where the RCGP can influence the prevention of future deaths within training and continuing professional development.

Yours faithfully

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