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NELFT NHS
NHS Foundation Trust

Sent by email to: Nadia.Persaud@walthamforest.gov.uk

PRIVATE & CONFIDENTIAL
Ms Nadia Persaud
Senior Coroner
Walthamstow Coroners Court
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Walthamstow
London
E17 8QP

Trust Head Office
Goodmayes Hospital
Barley Lane
Ilford
IG3 8XJ

Tel: 0300 555 1298
[redacted]

3rd August 2016

Dear Ms Persaud,

Re: Regulation 28 report following the inquest touching the death of Mrs Laura McRory

I refer to your Regulation 28 report dated 13th June 2016.

The Trust has carefully considered your report and is fully cognisant of the issues you have raised.

The Trust is committed to continuously review its service for the purposes of improving quality of care and patient safety and I am grateful for bringing these issues to my attention.

Please find enclosed the Trust's action plan to prevent the reoccurrence of the shortcomings identified in your Regulation 28 report.

Yours sincerely,

[redacted]
Chief Executive

[redacted]
Chief Executive

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ACTION PLAN IN RELATION TO REGULATION 28 REPORT TO PREVENT FUTURE DEATHS (LMcR)

JUNE 2016

Concern	Action to be taken	Timeframe	Lead	Progress/evidence
There is a need for a clear process to be in place for NELFT staff who require mental health care.	A protocol on the process for staff requiring mental health care to be developed and embedded in NELFT HR Policy. Managers and staff within NELFT to be made aware of the protocol via cascade, publication on staff intranet and via NELFT's Wellness Programme.	30th September 2016 31st October 2016	[redacted]	A draft protocol has been developed and is currently under consultation with staff. Protocol for NELFT staff to obtain help fc Action in process. Completion date on track.
The Trust investigation into this incident did not analyse to any degree the issues relating to the complexities surrounding NELFT staff seeking support for mental health conditions and whether there was an adequate safety plan in place on discharge.	Signing off of the SI reports – the SI policy and check list has been updated to strengthen the role of those signing off and setting TOR. This is currently out for comments. SI team awareness - a meeting has taken place to discuss the concerns raised. SI authors, team manager and those involved in SI sign off to undertake a reflective review meeting to discuss the process and identify learning.	30 September 2016 Completed 30th September 2016	[redacted]	Amendments to the SI policy.pdf SI meeting re Coroners feedback- N SI meeting re Coroners feedback- A Meeting booked for 24/08/16. Completion date on track.
There was an inadequate safety plan in place for LMcR on discharge from A&E.	To establish a clear protocol for the management for alcohol intoxication and substance misuse between psychiatric and medical services in Whipps Cross A&E.	31st October 2016	[redacted]	Action in process. Completion date on track.

[redacted]