East London
NHS Foundation Trust

Office of the Interim Chief Medical Officer
Trust Headquarters
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London E1 8DE

Private & Confidential

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27 March 2023

Dear Madam,

RE: Regulation 28 Response for Andrew Largin

This is a formal response to your Regulation 28 report dated 20 January 2023 where you set out concerns relating to the care of Andrew Largin whilst under East London NHS Foundation Trust's **(the Trust's)** care.

I understand that at the inquest into Mr Largin's death you heard evidence from the Trust's Serious Incident **(SI)** review author outlining the learning that has taken place as a consequence of his death. However, you remained concerned about the risk of future deaths in relation to the following areas:

1. *The ELFT serious incident (SI) review report identified that, although Mr Largin was discharged to the Woodberry Wetlands neighbourhood rehabilitation team from the crisis (i.e. home treatment) team on 25 January 2022, the neighbourhood team did not allocate him to a team member until 3 February.*

2. *The report also identified that, despite receiving an email from the Homerton University Hospital community rehabilitation team on 2 February, saying that Mr Largin had been seen on 1 February and was still very depressed, the crisis team failed to reassess him or to re-open his case to the crisis team, but instead referred the community team to the neighbourhood team.*

3. *However, the SI report did not identify that the crisis team member who made the decision on 2 February simply to advise that Mr Largin should be dealt with by the neighbourhood team failed to record any reasons for her decision.*

4. *The SI reviewer giving evidence in court said that the SI reviewing team had not even spoken to that crisis team member as part of their investigation, let alone fed*

back to her. He said they did not at the time realise that she still worked for ELFT, though he accepted that it would have been an extremely straight forward matter to find out. The crisis team member's manager gave evidence that she thought the relevant decision maker had left the team before Mr Largin's death, so between 3 and 6 February 2022. When I invited that manager to make a call while the inquest was ongoing to check, she later told me that the team member had not left the crisis team until 29 April 2022.

5. *It is believed, I was told, that there was a hot de-brief after Mr Largin's death. However, no notes were made of that and no entry was made on Mr Largin's medical record. Thus, nobody from ELFT found out what the decision maker's thinking had been, or what misconceptions she might have had that other staff members might share. The former crisis team member who made the decision still works for ELFT. As far as I could ascertain, her decision making concerning Mr Largin has never been discussed with her by ELFT managers.*

6. *The SI review also did not identify that members of the crisis team and the neighbourhood team did not share an understanding of how quickly the neighbourhood team aims to make contact with patients, to assist in their decision making about the correct pathway for a patient. In fact, a member of the neighbourhood team itself gave evidence about the response times that, I was told later, was not correct.*

7. *Finally, the operations lead for the neighbourhood team had great difficulty in giving me clear evidence about whether his team would or could refer a patient back to the crisis team if they felt the circumstances warranted. He demonstrated a lack of clarity on the point that I found very concerning.*

I wish to assure you and the family of Mr Largin that the Trust has reviewed the issues highlighted by the Regulation 28 report and has planned or undertaken the actions outlined below.

1. Allocation Times

I have reviewed your concern about the time gap between when Mr Largin was discharged from the City and Hackney Home Treatment Team (HTT) on 25 January 2022 to the Woodberry Wetlands Neighbourhood Rehabilitation Team (WWNT) and that a team member was allocated on 3 February 2022.

The WWNT's Operational Policy states that, '*The service provides a non-urgent mental health service and should see newly referred residents within and up to a maximum 28 days. Contact with the resident is to be made within a week of allocation to arrange an assessment appointment*.' It appears that a team member was allocated to Mr Largin, however it is unclear whether or not contact was made within a week

However, I agree that this may result in a care gap in some circumstances. With this in mind the WWNT are updating their Operational Policy to ensure that patients with the most serious mental health concerns are risk assessed within 7 days of referral to the WWNT.

This was discussed at the Joint Community/Crisis Service Quarterly Meeting on 17

March 2023. It is anticipated that the WWNT Operational Policy will be updated by 1st May 2023.I am happy to send a copy to the Coroner for its records.

2. CRISIS TEAM REASSESSMENT

The Deputy Borough Director of City and Hackney Directorate has explored in more detail, and with the relevant HTT member, the HTT's failure to re-assess Mr Largin and instead refer him to the WWNT. They confirmed to the Deputy Borough Director that the email was shared with the MDT and discussed. It appeared to the Deputy Borough Director that the MDT did not have a full picture of Mr Largin's needs leading to the decision to refer him to WWNT and not reassess him.

The City and Hackney Directorate is currently in the process of transforming the Crisis Pathway. Consequently, the HTT is presently being divided into two discrete sub-groups. A smaller number of staff will be allocated to a specific group of service users, with the goal of ensuring they have better knowledge of the service users individual needs. It is anticipated that this will greatly enhance continuity of care and ensure that the MDTs have full information when making decisions about appropriate referrals.

3. RECORDING CLINICAL RATIONALE

I was troubled that the Trust's SI review did not highlight that the relevant crisis team member did not record their rationale explaining why Mr Largin should remain with WWNT. I asked the Trust's Associate Director of Governance and Risk to explore this further.

They informed me that the SI Lead Reviewer did not interview the relevant crisis team member. They were advised that the crisis team member no longer worked with the team and made the incorrect assumption that the HTT member had left the Trust. The SI Lead Reviewer did not follow up with Human Resources (**HR**) to obtain the HTT members new contact details.

I am reassured by the Associate Director of Governance and Risk that amends have been made to the SI Lead Investigators and Co-Reviewers Responsibilities document so that going forward all staff members deemed relevant to an SI review must be contacted and approached via HR – as appropriate – to (a) advise that a SI Review is being undertaken and (b) request their involvement.

Additionally, the Deputy Borough Director for City and Hackney has reassured me that training will be provided to all HTT staff around documenting the following three principles of care:

1) What are you implementing?
2) Why are you doing it?
3) How are you doing it.

This has already been discussed in the Joint Community/Crisis Service Quarterly Meeting on 17 March 2023 and will form part of a Referrals and Screening training programmed being led by one of the Trust's consultant psychiatrists that will take start in March 2023 (see further details in point 6).

4. OMISSIONS

SI Author

I apologise to you and Mr Largin's family that the Lead SI reviewer did not interview the relevant HTT member, nor did they feed back their SI findings to them. I believe I have dealt with this matter fully in the query above.

Crisis Team Manager

I am aware that the HTT manager provided you with incorrect evidence about when the relevant crisis team member left the crisis team. All staff members have been made aware by the Deputy Borough Director that if there is any ambiguity about dates of employment when cooperating with investigations into service users' care they must contact HR. It has been emphasized how important precision in detail is in order for the Trust to learn from Serious Incidents.

5. HOT DE-BRIEF RECORD

Following serious incidents such as violence, aggression or death, clinical teams at the Trust hold a debrief as soon after the incident as is practicable. The debrief is usually facilitated by the manager or the team psychologist to explore thoughts and feelings around the incident, the impact on staff, the service user and the team. These incidents are not documented in the clinical notes as it is focussed on initial staff reactions and is not a formal process to look at lessons learned.

Initial learning after an incident is considered in a 48 hour report (which is completed promptly after the incident) and then in more detail in the subsequent SI report. It is expected that any learning discussed in the initial debrief (as outlined above) will be incorporated into the 48 hour report.

The process of effectively capturing learning from incidents is currently being reviewed as part of the Trust's implementation of the Patient Safety Incident Response Framework (PSIRF). It is anticipated that PSIRF will meaningfully address the current gaps in how the Trust's learning from incidents is investigated and recorded.

6. SHARED UNDERSTANDING BETWEEN CRISIS TEAM AND NEIGHBOURHOOD TEAM OF CONTACT TIMELINE

I have considered that the Trust SI review failed to highlight that there was no shared understanding between the HTT and the WWNT about referral timelines and I agree that this should have been explored.

To ensure that this does not happen again, the Associate Director of Governance has confirmed that during the Trust SI quality assurance process all SI Reviewers will be asked whether they have considered integrated working practices between different services.

Additionally, the Deputy Borough Director for City and Hackney has confirmed that the Neighbourhood Teams and Crisis Pathway teams (which includes HTT) are resuming their regular pathways meeting on 7 April 2023. They will produce an action plan around communicating a shared understanding of referral process and criteria.

Further, the Trust is implementing a training programme for all Neighbourhood Teams to highlight issues of clinical risk when triaging incoming referrals. This programme, due to start on 22 March 2023, will run monthly for 6 months in a rolling fashion. It aims to train staff and maintain a constant discussion in how to think about complex issues of risk for patients referred to the Neighbourhood Teams, whether that is from Crisis Pathway Teams (which include HTT), GPs, or elsewhere. It will use didactic teaching, role play with actors, sample cases, discussion, and reflection, and will be facilitated by an experienced Consultant Psychiatrist, as well as the Associate Clinical Director for the Neighbourhood Teams. An important part of this training will be to improve understanding of referrals and risk signifiers from the Crisis Team to the Neighbourhood Team.

7. Referral to Crisis Team

The Deputy Borough Director has spent time reviewing procedures for both the HTT and WWNT. He has also met with the relevant managers. He is reassured that all WWNT members are clear on the standard operating procedure for how WWNT clinicians may refer service users back to the crisis team.

The Deputy Borough Director has also explained to WWNT staff members that they must be able to clearly explain Trust procedures to the Coroner as part of their clinical roles. To facilitate this, they will all be required to attend the next Coroner's Training provided by the Trust's Legal Affairs Team which is currently being planned.

I hope I have provided reassurance to you and the family of Mr Largin about the learning that has taken place as a consequence of his sad death.

I offer my sincere and heart-felt condolences to the family at this difficult time.

Yours sincerely,

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Interim Chief Medical Officer

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