Regulation 28: Prevention of Future Deaths report

Andrew Mark LARGIN (died 06.02.22)

	THIS REPORT IS BEING SENT TO: **1. [redacted]** **Chief Executive Officer** **East London NHS Foundation Trust (ELFT)** **Trust Headquarters** **9 Alie Street** **London E1 8DE**
1	**CORONER** I am: Coroner ME Hassell Senior Coroner Inner North London St Pancras Coroner's Court Camley Street London N1C 4PP
2	**CORONER'S LEGAL POWERS** I make this report under the Coroners and Justice Act 2009, paragraph 7, Schedule 5, and The Coroners (Investigations) Regulations 2013, regulations 28 and 29.
3	**INVESTIGATION and INQUEST** On 10 February 2022, one of my assistant coroners, Jonathan Stevens, commenced an investigation into the death of Andrew Mark Largin, aged 60 years. The investigation concluded at the end of the inquest last Friday, 20 January 2023. I made a determination at inquest that Andrew Largin died by suicide. His mental health had been identified as deteriorating by a community rehabilitation team on 1 February 2022. That team notified the home treatment team who had discharged him from their care on 25 January 2023. However, the home treatment team failed to reassess him.
4	**CIRCUMSTANCES OF THE DEATH**

	Mr Largin asphyxiated himself in the early hours of 6 February 2022, at the home of his sister and brother in law where he lived. His medical cause of death was: 1a) asphyxia 1b) inhalation of inert gas
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. 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. 5. 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.

	6. 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. 7. 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. 8. 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. 9. 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.
6	**ACTION SHOULD BE TAKEN** In my opinion, action should be taken to prevent future deaths and I believe that you 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 27 March 2023. 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 following. • [redacted] sister of Andrew Largin • HHJ Thomas Teague QC, the Chief Coroner of England & Wales

	I am also under a duty to send a copy of your response to the Chief Coroner and all interested persons who in my opinion should receive it. I may also send a copy of your response to any other person who I believe may find it useful or of interest. 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.	
9	**DATE** 25.01.23	**SIGNED BY SENIOR CORONER** *ME Hassell*