NHS
Leicestershire Partnership
NHS Trust

Leicestershire Partnership NHS Trust
Bridge Park Plaza
Bridge Park Road
Thurmaston
Leicester
LE4 8PQ

Date: 9 October 2023

Dear Miss Thistlethwaite

Re: Miss Marie Zarins

Further to your report dated 14 August 2023, in accordance with paragraph 7, Schedule 5 of the Coroners and Justice Act 2009 and Regulations 28 and 29 of the Coroners (Investigations) Regulations 2013, I offer the following response.

We have investigated the matters of concern that have arisen during the course of the inquest of Miss Marie Zarins, Leicestershire Partnership NHS Trust takes these matters very seriously. The matters of concern you have raised are as follows:

1) I am concerned about the CRISIS team MDT meetings and their functionality. It is difficult to understand how a meeting attended by around 7 people agreed a treatment plan which was based upon incorrect information relating to the patient's medication status. This is particularly difficult to understand when the correct medication status is clearly documented in the patient's core assessment paperwork (which was completed by the Liaison Team on 22 November 2021 and sent to the CRISIS Team).

An LPT staff member was candid about the fact that he did not have enough time to review patients' records before the MDT meetings, this is a grave concern.

<u>Crisis Team MDT</u>

Medical input was provided by a Locum Consultant who was not a substantive member of LPT staff.

Whilst the Locum Consultant held the belief that the patient was on prescribed anti-depressant medication, the Crisis Team was not in agreement with this, it was their understanding that the patient was not on prescribed anti-depressant medication; the team highlighted in the original investigation that they had made this known to the Locum Consultant during the MDT meeting. The MDT documented the patient's treatment plan which was based on psychosocial intervention.

<u>LPT staff member not reviewing the patients record.</u>

We confirm that prior to the MDT meeting, the Locum Consultant accessed SystmOne for a period of seven minutes. We also confirm that they did not raise any concerns regarding MDT meetings with the Clinical or Medical Director.

The Trust was unable to contact the Locum Consultant for input into the original SI investigation due to not holding the latest contact details; the Locum Consultant was no longer contracted to work with the Trust, and they had left the country.

The Trust was unaware of any information from the Locum Consultant's perspective and could not include the new evidence provided by them on the day within the initial SI report. Whilst we notified you of this lack of engagement on the day, we understand that you were not aware of this when initially reading the SI report. We now include a limitations section in our SI reports so that it is clear if there are any areas that we have been unable to include within the investigation.

As agreed during the inquest, contact details were shared with the Trust and the Locum Consultant is now engaging in our review of the original SI report.

2) I remain concerned about both the standard of documentation and lack of documentation relating to the discussion of Miss Zarins at the two MDT meetings. The Trust were only able to provide me with documentation relating to one of the two MDT meetings. That documentation is incorrectly completed and lacks detail. In particular, there is no detail about medication despite there being a specific box within which to document this.

This problem of poor and/or missing documentation is not a risk that is limited to the CRISIS Team, it is one that could have ramifications not only across the Trust but across all of the bodies who come together to provide care for patients.

We confirm that notes from the two MDT meetings are available and we recognise that only one set was initially shared with you. The second MDT was held at 10:00 on the morning of Miss Zarin's death and therefore any decisions made and plans formulated would not have been actioned in time to provide support to her. We will provide further detail of this MDT meeting in our review of the initial SI report.

In order to learn and improve, the Trust has actioned a quality improvement programme which will review our MDT processes and improve the functionality of the recording and documenting of MDT meeting notes. This is focussed within the Crisis Team initially and will be further rolled out to Community Mental Health Teams and inpatient areas. We will capture the learning from this inquest and other SI reports produced by the Trust and will share this learning across the Trust through our learning forums and Quality Improvement Collaboratives.

3) I remain gravely concerned about the inadequacies in the Serious Incident Investigation and Reporting processes at Leicestershire Partnership NHS Trust. The Serious Incident Investigation failed to identify the errors in the care provided to Miss Zarins making the use of the process somewhat otiose in this case. The failure to properly investigate led to the wholly untenable situation where errors in care were uncovered for the first time at inquest, which took place some 20 months after the date of death (due to witness availability).

I am concerned that the lack of robust critical analysis and investigation of the care opportunities (for some staff) to learn lessons that are vital to patient safety. My concerns relating to the inadequacy of the Trust Serious Incident Investigations and the risks related to that go far beyond just the care provided by the CRISIS Team.

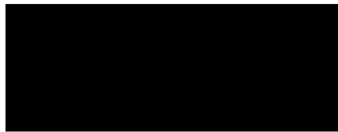
The risks have the ability to prevent learning, therefore negatively impact upon patient safety, across the entire Trust.

Earlier this year, the Royal College of Psychiatrists' Serious Incident Review Accreditation Network (SIRAN) awarded accreditation to the Trust for our Serious Incident (SI) processes. This is a national quality improvement and accreditation network for Mental Health Trusts. This accreditation concentrates on the quality of investigations and reviews and ensures processes are in place to work meaningfully with patients, their families and staff equally to identify learning. We were awarded this accreditation in recognition of the high standard of SI reporting undertaken by the Trust in 2023. We believe that this demonstrates the pace and extent of improvement undertaken since the time of the SI report in relation to Miss Zarin's death. We continue to build on this as we transition towards the Patient Safety Incident Response Framework.

As a Trust we are all committed to ensuring that all the identified service actions are robust and completed within the agreed timescales. We hope this reassures you that we are taking appropriate action in response to your findings.

If I can be of any further assistance to you please do not hesitate to contact me.

Yours sincerely



Chief Executive