Regulation 28: REPORT TO PREVENT FUTURE DEATHS

NOTE: This form is to be used **after** an inquest.

	REGULATION 28 REPORT TO PREVENT DEATHS **THIS REPORT IS BEING SENT TO:** **Chief Executive, Leicestershire Partnership NHS Trust (via their legal representatives)**
1	**CORONER** I am Miss Isobel Thistlethwaite His Majesty's Assistant Coroner for the coroner area of Leicester City and South Leicestershire
2	**CORONER'S LEGAL POWERS** I make this report under paragraph 7, Schedule 5, of the Coroners and Justice Act 2009 and regulations 28 and 29 of the Coroners (Investigations) Regulations 2013.
3	**INVESTIGATION and INQUEST** On 02 December 2021 I commenced an investigation into the death of Marie ZARINS aged 42. The investigation concluded at the end of the inquest which took place on 13 and 14 July 2023. The conclusion of the inquest was: Suicide The cause of death was established as: I a Hanging (suspension by ligature) I b I c II
4	**CIRCUMSTANCES OF THE DEATH** Miss Zarins was a 42 year old female who was reported missing by her family and discovered suspended [redacted], Leicestershire. Her death was confirmed at the scene by one of the attending paramedics on 24 November 2021 at 16:04hours.

5	**CORONER'S CONCERNS** During the course of the investigation my inquiries revealed matters giving rise to concern. In my opinion there is a risk that future deaths could occur unless action is taken. In the circumstances it is my statutory duty to report to you. The **MATTERS OF CONCERN** are as follows: **Pre-amble** The inquest heard evidence that Miss Zarins had suffered with depression since 2008. She managed this by taking anti-depressant medication intermittently, she stopped taking her anti-depressants in June/July 2021. Miss Zarins came under the care of Leicestershire Partnership NHS Trust ("LPT") on 22 November 2021, after taking an intentional overdose the day before. Miss Zarins was initially under the care of LPT's Mental Health Liaison team but was transferred to the care of LPT's CRISIS Team when she returned to her home address on 22 November 2021. Miss Zarins expressed a desire to work with the CRISIS team and to recommence anti-depressants as soon as possible in order to improve her mental health. On 23 November 2021 Miss Zarins was discussed at a Multi-Disciplinary Team ("MDT") meeting at LPT. The discussions at that meeting were fundamentally flawed, as was the plan for Miss Zarins' care moving forward that was formed at that meeting and then implemented. The meeting proceeded on the basis that Miss Zarins was on, and had been on, anti-depressant medication at the time of taking the overdose, this was incorrect. The second and final MDT meeting where Miss Zarins was discussed (on 24 November 2021) also proceeded on this same mistaken basis. Despite Miss Zarins verbalising both her desire to get more sleep and her desire to go back onto anti-depressants as soon as possible, neither sleeping tablets nor anti-depressants were prescribed to her by LPT before she died. LPT continued to advise Miss Zarins that she would have to wait until 30 November 2021 to have a medical review. A member of LPT staff who was present at both MDT meetings informed the inquest that he did not have time to read the notes of the patients that were to be discussed at the MDT meetings. The staff member had not read Miss Zarins' core assessment documentation (which correctly stated she was not on any anti-depressants) before either MDT meeting. Evidence heard at inquest was that Miss Zarins should have been put back onto anti-depressants and prescribed sleeping tablets on 23 November 2021. LPT undertook a Serious Incident Investigation into the care provided to Miss Zarins before her death. The investigation was wholly inadequate. Issues include, but are not limited to: 1. There was no medical input into the investigation; 2. The investigation failed to explore appropriately the functionality of the MDT meetings;

3. The investigation failed to identify the error in understanding of the Miss Zarins' medication position;

4. Due to the fact that the investigation failed to identify the error relating to the understanding of the medication position, the investigation also failed to identify the fact that the treatment plan that was implemented was flawed. The investigation failed to identify the fact that Miss Zarins should have been recommenced on anti-depressants and prescribed sleeping tablets before her death.

Notwithstanding the inadequacy of the Serious Incident report the document accepts that, whilst the anti-depressants would not have had an immediate impact on Miss Zarins' mood, the thought of having to wait a week for this medication may have added to her sense of hopelessness. This was echoed by witnesses at the inquest. I also accept, on the balance of probabilities, and when considered alongside Miss Zarins' clear desire to recommence her anti-depressants in order to get better, that the fact she was told she had to wait a week for a medical review would have added to her sense of hopelessness.

Concerns

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.

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.

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

	provided to Miss Zarins before her death has caused a delay to, and led to missed 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.
6	**ACTION SHOULD BE TAKEN** In my opinion action should be taken to prevent future deaths and I believe you (and/or your organisation) 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 October 15, 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 Chief Coroner and to the following Interested Persons **1. [redacted], father and mother of the Deceased** **2. [redacted], brother of the Deceased** **3. [redacted], partner of the Deceased** **4. Leicestershire Partnership NHS Trust (via its legal representatives)** 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 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 by the Chief Coroner.
9	**Dated: 14/08/2023**  **Miss I THISTLETHWAITE** **His Majesty's Assistant Coroner for Leicester City and South Leicestershire**