Office of the Chief Medical Officer
Trust Headquarters
5th Floor
9 Alie Street
London E1 8DE

Private & Confidential

Ms Emma Whitting
HM Senior Coroner
[redacted]

[redacted]

29 January 2024

Dear Madam

RE: Regulation 28 Response – Angela Collins

I am writing on behalf of East London NHS Foundation Trust ('the Trust') to provide a formal response to the Regulation 28 Report that you issued following the inquest touching the death of Ms Angela Collins.

The Trust has carefully considered your Regulation 28 Report at the most senior clinical level. Following the tragic passing of Ms Collins, the Trust extends it most sincere condolences to the family and has very carefully considered your notice by extending a further review of all relevant circumstances surrounding this case.

In your Notice, you wrote that "vulnerable adults at risk of accidental/intentional prescription drug overdose and potentially suffering a mental health crisis (such as Angie) appear to receive very limited or no support even though they are under the care of secondary mental health services provided by East London NHS Foundation Trust."

At the inquest, you heard evidence that although Ms Collins' relationship with her Care Co-Ordinator had broken down, she was being supported by a different member of staff who was very experienced.

The Trust's original investigation sets out that Ms Collins was discussed by the Multi-Disciplinary Team (MDT) on the 10th and 17th of August. After Ms Collins left her home on 18th August and was subsequently seen by the Police, they

communicated that they thought Ms Collins was at a 'normal' or medium level of risk, and that she had denied any thoughts of harming herself.

Whilst evidence provided by the CMHT indicated that attempts were made to contact Ms Collins, albeit that there were documented difficulties in her engagement with the service, the Trust is now of the view that given Ms Collins complex family situation, her recent hospital admission due to a third attempt of suicide, the reports of concerns regarding a deterioration in her mental health, the fact she had not been seen by a qualified mental health professional since 14th July 2022, and her concerns relating to her being able to continue to see her children, which was noted as a protective factor, the CMHT should have considered undertaking a visit to Ms Collins, once it was established that she was staying at the hotel.

Furthermore, the Trust is of the view that given the recorded difficulties between Ms Collins and her Care Coordinator and the situation that was unfolding, consideration of identifying an alternative practitioner from the team to visit her at the point she had been located at the hotel, would have provided an opportunity to assess the gravity of the situation first hand and make attempts in negotiating appropriate care and support to Ms Collins, at that time.

In light of HM Coroner's observations, the Trust has further reflected on the details of this case to see if there are actions that can be taken to further strengthen care in such circumstances. The Trust is now assessing the impact of the learning from this case and related previous cases to ensure that changes to practice are properly embedded and support is provided to staff on an ongoing basis. In doing so, the Trust believes vulnerable adults at risk of accidental/intentional prescription drug overdose and potentially suffering a mental health crisis (such as Ms Collins) will be supported appropriately. A detailed action plan is being developed with colleagues and will include items listed below. Please note that references to staff and managers are to CMHT staff in the Luton and Bedfordshire Directorate.

1. A robust review of the Duty Function including how it is resourced, training requirements, practice standards, and senior oversight, across all Community Mental Health Teams in Bedfordshire and Luton. This work will commence in February 2024.
2. Engage with administrative staff (who are usually the first people to talk to a service user and/or their carer) to clarify the purpose of their role in terms of supporting people over the phone who may be in distress and providing robust/timely support. This will include clarifying and getting their feedback on training needs and clear escalation pathways, plus ensuring that opportunities for reflection and de-briefs are made available.
3. Work with system partners to review the *current 'Multi-Agency Vulnerable Adult Return Home Interview Practice Guidance'* which was due to be reviewed by 06-Jul-2022.

4. Ensure all staff attend the recently established 'Think Family, Supporting people in complex family environments' training. Establish a feedback mechanism that monitors the impact and success of putting learning into practice.

5. Ensure that all managers are aware of and implement the People in Position of Trust (PIPOT) protocol which provides a framework to investigate allegations made by service users and ensures that both service users and staff are supported appropriately. This will also enable MDTs to consider appropriate and proportionate steps where a service user refuses to engage with their allocated worker thereby reviewing all the relevant facts of the case and mitigating against any potential increased risk to that person.

6. Review the appropriate multi-agency protocol to ensure that staff are clear on the need for clear communication when supporting a person alongside other agencies and that roles and responsibilities are clearly articulated and where necessary reviewed to respond to ongoing and evolving circumstances. That records are both accurate, detailed, and timely and reflect the situation as it unfolds.

7. That all teams provide clear routes of escalation to partner agencies if there is discourse or disagreement about how a case is being managed utilising the system-wide Cooperation between Teams protocol.

The Trust prides itself on being a learning organisation that is constantly seeking to improve practice and the services it provides. In considering the Prevention of Future Deaths Notice and reflecting on the case again, the Trust feels assured of the learning that arises from this tragic event.

Yours sincerely,

[redacted]

[redacted]
Chief Medical Officer