North London Mental Health Partnership

NHS
Barnet, Enfield and Haringey Mental Health NHS Trust
Camden and Islington NHS Foundation Trust

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Private and Confidential
Ms Mary Hassell
Senior Coroner
Inner North London
St Pancras Coroner's Court
Camley St
London N1C 4PP

1 July 2024

Dear Coroner Hassell

Re Inquest Touching the death of Emmanuel Ladapo

I am writing further to the inquest for Mr Ladapo which concluded on 22 April 2024 and following which you issued a Prevention of Future Deaths report (PFD). The matters of concern raised were;

1. That there was no evidence of engagement with Mr Ladapo's sister, who was keen to be involved in his care, either generally during his care and treatment with the Trust's Early Intervention Service and Rehabilitation and Recovery Team or at specific points during this time. You note that lack of engagement with families is a recurring theme at inquests and you specifically reference four previous PFD reports issued to Camden and Islington NHS Foundation Trust (C&I) between 2015 and 2021 which raise this issue.

2. That at consultations in January and February 2023 when Mr Ladapo was noted to have deteriorated, on both occasions the psychiatrist omitted to ask him whether he was suicidal. You observed that this is an omission you have also written to C&I about before and that it was not identified in the Trust's incident report. You are concerned that this issue does not feature highly enough in the consciousness of staff at C&I.

Thank you for raising these points which have been carefully considered from a service improvement perspective. I take this opportunity to advise you that, although in your report you make reference to C&I, this response is framed from a partnership perspective in line with the North London Mental Health Partnership (NLMHP) arrangement between C&I and Barnet Enfield and Haringey Mental Health NHS Trust (BEH) as we move forward to becoming a single trust in October this year. Therefore, the learning from this will be shared across the whole partnership.

I can advise the following:

Engagement with families

Firstly I would like to say how very sorry we are that we did not explore engagement with Mr Ladapo's sister; the team involved recognised this missed opportunity in their own reflections on what happened and will have it at the forefront of their minds going forward. We fully recognise the importance of high-quality engagement of families, or those identified people who are important to our service users, as equal partners in care and we are in the process of ensuring an organisation-wide commitment by creating a Carers Strategy, a Carer focused educational 'Community of Practice' and a programme of Carers Awareness Training for staff across the Partnership. We have an 'involvement register' which includes carers and is promoted as a way for them to positively influence the organisation both locally and at a wider partnership level. For example, a group of Carers have been engaged in co-producing a carers leaflet template which all our services will be expected to implement and make available to families. Some were also recently involved in the development of our Partnership Clinical strategy as part of the coproduction working group.

There is also a specific workstream focused on Service User and Carer Engagement and Experience as part of our Quality Improvement programme, called 'Brilliant Basics', which seeks to ensure that the fundamentals of high quality care are fully embedded in areas needing attention. This programme helps us to provide the right care, first time, every time and is made up of a series of workstreams that create and track positive change. We held two workshops with Carers in December 2023 and February 2024 and engaged with a wider group of them through surveys. From this we have mapped the areas that families/carers feel will drive positive change in practice to improve engagement with them and their experience. Identifying patients' support networks and recording this is a priority area. A Carers Partnership Board is being set up and will commence by August 2024. This will provide formal assurance for this Brilliant Basic workstream as well as monitor feedback and activity in relation to carers, including how well we are identifying and engaging families, plus look at Carer Experience and Involvement work from all our divisions. The meetings will include Carer representation from each Division. This Carer Partnership Board will report into the Partnership Quality and Safety Group.

We are currently undertaking a pilot project in partnership with Camden Carers and Islington Carers Hub, which introduces a couple of Carer Peer Support Coach roles. The project is designed to increase an awareness of carers amongst inpatient and community clients and staff. The testing and evaluation of this model will inform whether further utilisation of employees with explicit experience of unpaid caring can increase the quality of care being delivered within specific teams.

Risk Assessment / Asking about suicidality

With regard to the individual psychiatrist who reviewed Mr Ladapo and the omission of a comprehensive assessment of suicidal risk, he is receiving increased clinical supervision sessions from a consultant psychiatrist and the necessary learning has been highlighted both in his supervision and in his appraisal. Through reflection on his own practice, he is now more mindful of incorporating detailed risk assessments into his future practice and this has been confirmed through clinical supervision. We agree that there is a general need to ensure that staff are aware of the importance of asking about suicidality and that they do so in practice because this is a fundamental part of a mental health assessment. Assessing suicidal thinking is an essential part of the training curriculum for doctors specialising in psychiatry. Any issues about safe clinical practice including carrying out comprehensive assessment of a patient's risks should be picked up in clinical supervision discussions.

More broadly, the trust is undertaking a review of risk assessment looking at systems and processes and also training for our staff.

Learning from Incidents and PFDs

We, in the NLMHP, are committed to sustainable learning across all our services. We recognise that this case has highlighted themes that have been raised in previous PFDs, whilst wishing to note that every case is different and that there are nuances between cases which may explain why things were done as they were. For example, and whilst not the case here, many of our service users may not consent to involvement of their families. Nevertheless we recognise that in the past some of our processes around learning have not been as robust as they could have been and we are constantly working to improve and strengthen these. Whilst all service areas learn within their individual team governance meetings and across their divisions too, we have a Partnership 'Weekly Incident Review Group' meeting that is a forum for communicating recent incidents and risks alongside our Partnership weekly Safety Huddle. Any significant learning using the 'Patient Safety Incident Response Framework' (PSIRF) is presented at our newly set up (16th May 2024) 'Shared Learning Collaborative' that allows reflection of learning elements to disseminate across all divisions and disciplines within our Partnership. The sustained learning historically and more recently from this recent incident was presented at our 20th June collaborative meeting, for all our respective divisions and clinicians to understand further. Learning from inquests is also regularly featured in bulletins and reports.

I hope that this provides you with helpful information and context. If you have any further queries, please do not hesitate to contact me.

Yours sincerely

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Chief Medical Officer