Leicestershire Partnership
NHS Trust

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8 August 2024

Dear Miss Thistlethwaite

Christopher Henrik Larsen

Inquest date: 21st March 2024, 10th May 2024, and 13th June 2024

On behalf of Leicestershire Partnership NHS Trust (hereafter 'the Trust'), I am responding to your Report to Prevent Future Deaths (hereafter "your Report") dated 13th June 2024 concerning the death of Christopher Henrik Larsen. In advance of responding to the concerns raised in your report, I would like to express my deepest condolences to Mr Larsen's family and loved ones. The Trust wishes to assure the Larsen family and HM Assistant Coroner that the concerns raised about his care have been listened to, reflected upon and actions have been taken as a result.

Concern 1: Multi-disciplinary Team (MDT) Meeting

"I am concerned about the Leicestershire Partnership NHS Trust MDT meetings and their functionality. Mr Larsen was discussed at three meetings, at two of the three meetings none of the attendees had met Mr Larsen. It was at an MDT meeting where Mr Larsen was deemed to be "low risk" (having initially been deemed to be high risk by the Central Access Point), it is not possible to understand why Mr Larsen's risk was downgraded to low risk by the MDT meeting because the MDT meeting documentation does not contain that information. The issue of poor documentation relating to MDT meetings and their decision making is something which could have ramifications across the whole Trust and also for other bodies who come together to provide care for patients. The MDT meeting either misread or misunderstood Mr Larsen's medical records. The notes document that Mr Larsen explained that he had previously placed

a bag over his head and that this remained the way he would end his life, he advised that he could not give assurances that he would not try to do this again. The MDT documentation however states that Mr Larsen "wrapped plastic bag over his face but self-rescued, does not want to do it again." This is incorrect. The MDT meeting therefore proceeded, and made decisions based upon, incorrect information. There were several requests made to MDT meetings for Mr Larsen to have a medic review, the MDT Regulation 28 – After Inquest Document Template Updated 16/05/2023 deemed this to be unnecessary but there is no documentation explaining the rationale of those decision. The Trust SI report states that "it is unfortunate that he was not reviewed by a medic." At the second MDT meeting on 17th November the working diagnosis in relation to Mr Larsen was an acute stress reaction. This working diagnosis was not revisited at the third MDT on 22nd November. The Trust's SI report states that by 17th November there was evidence of a severe depressive disorder, this potential diagnosis was not identified or explored by the MDT meeting."

As part of immediate learning and action taken relating to the concerns you have raised directly about the MDT meeting and documentation, we have reviewed and made substantial changes to the MDT template to be used for MDT meetings [Appendix 1]. In addition, after engagement with clinical staff and extended reflection on the death of Christopher Larsen, we have also implemented a process to provide further clarity on the reason for referral into the MDT meeting via pre-MDT sections to be completed on the MDT template. This template will be completed by the clinician who had the last clinical contact with the patient prior to the MDT meeting. The information captured in this template and the reason for the referral into the MDT meeting will be discussed with the patient at this clinical contact and will support the information captured within the patient's notes and risk assessment.

The MDT meeting attendance has also been reviewed to include a senior nurse clinician to oversee the process along with medical colleagues and other members of the crisis service. The MDT meeting will utilise the information within the pre-MDT template and the most recent Core assessment, Risk assessment and the contemporaneous clinical notes to inform the clinical discussions. The discussions within the MDT will be captured in real-time in the MDT template and the outcomes, decisions and actions agreed and documented; the MDT template forms part of the patient notes and will be immediately available. The template also enables specific actions and owners to be captured, this includes responsibility for contacting the patient to inform them of the outcome as a follow-up to the clinical consultation which prompted the referral; this also enables a further opportunity for the clinician to understand if the clinical presentation has changed since the referral was made.

To provide assurance to the Directorate senior clinical team, audits will be undertaken monthly to ensure the processes and documents are being completed fully and to the standards expected. Feedback from the audits will be shared with the staff involved via their weekly meeting to ensure they are aware of areas requiring improvement. The outcomes of the audit will be reviewed within the Directorate Quality and Safety Governance meeting, with evidence of learning shared; this will be monitored monthly. In addition, the Chief Nurse and Medical Director will review the audits, sample of decisions and outcomes of the new process in six months to provide additional assurance and scrutiny.

The process was implemented on 08 July 2024 and the outcome of the first audit is due to go to the Directorate Quality and Safety meeting on the 22 August 2024.

In addition to the above, there is an opportunity for key clinical discussions to be held in daily team debriefs based on clinical need; the outcomes of which will be documented in the patient notes and discussed with the patient if required.

The Crisis Resolution Home Treatment Team Standard Operating Procedure (SOP) [Appendix 2] has also been reviewed and amended to clearly explain all these processes for our staff and includes specific guidance on how to identify when a medical review should be considered/offered as this is not required for all patients. The revised SOP was agreed on 24 July 2024 and was circulated to all staff via email on 25 July 2024; it was also shared in team meetings which take place weekly. Staff have been required to sign a confirmation that they have read and understand the SOP and the new process.

Concern 2: Risk Assessment

"At his initial triage (undertaken by the Central Access Point) Mr Larsen was deemed to be high risk. At a later MDT meeting Mr Larsen was deemed to be low risk. It is not possible to explore the rationale behind the downgrading of Mr Larsen's risk to low because there is no documentation about the decision making. The Trust's SI report identified the fact that several "red flag" risk factors which applied to Mr Larsen were not "robustly considered" when assessing Mr Larsen's risk. The Trust's SI report states that it was "unclear why it was felt the risks had subsided by the time of discharge on 3.12.2022."

Clinical risk assessment is a dynamic process undertaken by clinicians when they are with the patient, considering all information relating to a patient with the view of assessing the likelihood of the patient acting in a manner which may be harmful to themselves and/or others. Part of a clinical risk assessment includes the consideration of risk factors. Risk formulation as part of the risk assessment brings together an understanding of personality, history, current mental state, environment, potential causes and protective factors, or changes in any of these. If there are indicators which would indicate the presence of increased risk factors, then these will be explored on a case-by-case basis by the assessing clinician.

The risk assessment undertaken by the clinician presenting a case to the MDT, forms part of the information considered by the MDT in accordance with NICE [NG225] guidelines which state that decisions about care should not be made based on risk assessment tools and should be based on clinical formulation. Additionally, they state that the forementioned 'red flag' risk factors alone do not indicate the likelihood of self-harm or suicide amongst the patients under crisis (who by the nature of their presentation, would all be deemed at a higher level of risk than those in the general population). The MDT considers the clinicians assessment of risk at the time of assessment. When the outcome of the MDT is shared with the patient, it offers a further opportunity for the clinician to assess whether the risk presentation has changed from the previous assessment.

As the assessment of risk is a key component to the effectiveness of the clinicians working within the Crisis team, the Trust is completing a review of our competency framework and the audit tool to support the monitoring of robust documentation of risk assessment/formulation. This review was completed on 02 August 2024. The outcomes of the review will be presented to the Urgent Care Quality and Safety Meeting on the 22 August 2024 to inform any required changes.

Concern 3: Discharge

"Mr Larsen was discharged from the care of LPT on 3 December 2022, there was no planned support for Mr Larsen post-discharge other than some counselling which was due to start three weeks later. The Trust's SI report states that it is "unclear why it was felt the risks had subsided by the time of discharge on 3.12.2022" and that Mr Larsen had the "presence of ample markers for high risk of completed suicide" yet he was discharged back to the care of his GP and into a lacuna of care with no pre-arranged support other than counselling which would not commence for three weeks."

The Crisis Resolution Home Treatment Team is a short-term, needs-based intervention service whose primary role is to mitigate the requirement for inpatient admission to an acute mental health hospital setting. Patients are referred into the service for intensive home treatment from a variety of different settings, including both primary and secondary care. For a substantial number of patients who have received care from the team, a referral into secondary care is not clinically appropriate or indicated. Many patients are subsequently discharged back to primary care following the formulation of a clear crisis and contingency plan which is formulated in collaboration with the patient (and carers where applicable).

A crisis and contingency plan includes information about how, where and when a patient can seek support for their mental health should the need arise, including the identification of 24-hour access to mental health support via the Urgent Care Pathway within LPT (set up in line with the requirements set out by NHS England Five Year Forward View (2014), the NHS England Long Term Plan (2019) and the Crisis Care Concordat (2014) which state that people with mental health problems should be able to get help 24 hours per day before they get to crisis point.

At the point of discharge from the Crisis Team, the decision is discussed and explained to the patient and a discharge letter is formulated which outlines the care a patient has received, alongside any changes to their medication and a copy of their crisis and contingency plan. Additionally, within the discharge meeting with the patient their risk assessment is formally updated on their records to accurately capture any significant changes to their risk profile and clinical formulation both whilst under the care of the team and at the point of discharge.

The Crisis Resolution Home Treatment Team's SOP states that all patients will only be discharged following an MDT discussion. Should a patient request early discharge (earlier than planned) from the team, the case will be escalated to a CRHT consultant and/or the Duty Team Lead. At this point, the patient's care and clinical presentation (including risk formulation) will be considered, and a decision about discharge (or escalation of care) will be made and documented in the patient's notes. It is important to note that should it be felt following a clinical review of presentation that there is an

increased likelihood of a patient acting in a manner which may cause harm to themselves and/or others if they were to be discharged early from the team, then care would be escalated depending on urgency at this point. Examples of this may include the consideration of a formal Mental Health Act Assessment or escalation to emergency services for immediate risk concerns.

Concern 4: The Serious Investigation (SI) and Reporting Process at LPT

"I remain concerned about inadequacies in the Serious Incident Investigation and Reporting processes at Leicestershire Partnership NHS Trust. The Serious Incident Investigation into Mr Larsen's death did uncover and accepted some failings in relation to the care provided to Mr Larsen. However, it failed to uncover all the matters arising at inquest and, some of the matters that it did uncover do not have correlating items of work listed in the action plan. There was no exploration of the MDT meeting's functionality or documentation as part of the SI investigation. Further, I have concerns about the implementation and embedding of the lessons learned which are identified by the SI Report. In this case the live witnesses who gave evidence during the course of the inquest did not demonstrate that learning had filtered down to the front-line staff. I am therefore concerned that the SI process at LPT does not support a robust and critical analysis and investigation of the care provided to patients, further, I have concerns about the ability of the Trust to embed changes and learning. This failure to properly explore matters and learn where possible inevitably leads to a delay, or failure altogether, to learn lessons which are vital to patient safety across the whole Trust."

We take learning form serious incidents very seriously and have taken on board feedback provided relating to the processes within the Trust. All serious incident reports are reviewed by the Medical Director and Chief Nurse to ensure that they provide a critical analysis and investigation of the care provided to patients. We also recognise that the transition to the new National Patient Safety Incident Response Framework (PSIRF) has taken time to embed. Feedback from the new PSIRF process has been positive from families and clinicians. In order to make the process more robust a rapid improvement programme is underway to utilise quality improvement methodology to identify any improvements which can be made to the process.

In addition, the Director of Nursing and the Medical Director have initiated quality summits that have focussed on safety, leadership, and governance within the crisis pathway. The summits have been a collaborative space involving leaders and staff within the service to ensure accountability and learning.

I trust that the proposed actions that we have described above do collectively provide assurance that the Leicestershire Partnership NHS Trust is taking a number of immediate measures to respond to the concerns set out by HM Coroner in her Report.

Thank you for bringing these important patient safety issues to my attention and please do not hesitate to contact me should you need any further information.

Yours sincerely

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Chief Executive

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Appendix 1 MDT template
Appendix 2 The Crisis Resolution Home Treatment Team Standard Operating Procedure (SOP)