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:** **The Chief Executive, Leicestershire Partnership NHS Trust via their legal representatives**
1	**CORONER** I am Miss I THISTLETHWAITE, His Majesty's Assistant Coroner for the coroner area of Rutland and North 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 17 January 2023 I commenced an investigation into the death of Christopher Henrik LARSEN aged 52. The investigation concluded at the end of the inquest on . The conclusion of the inquest was that: The cause of death was established as: I a Hanging by Ligature I b I c II
4	**CIRCUMSTANCES OF THE DEATH** Mr Larsen was a 52 year old white male who, on 6 January 2023, was found hanging at his home in Leicestershire.
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

Mr Larsen was a 52 year old male with no history of mental health problems until he presented to his GP in November 2022 to discuss a decline in his Mental Health. Mr Larsen reported going through a very difficult time, his business was being liquidated and he felt he had let his family and business associates down. Mr Larsen advised the GP that he had placed a bag over his head a few days before the consultation but stopped short of seeing his attempt to end his life through because he thought about his children who were a protective factor for him.

Mr Larsen's GP referred him to the CRISIS Home Resolution Treatment Team, part of the Leicestershire Partnership NHS Trust, who accepted him for a period of treatment. Mr Larsen was seen regularly by the team and commenced on medication. Mr Larsen was discharged from the CRISIS Home Resolution Treatment Team on 3 December 2022.

On 4 January 2023 Mr Larsen contacted the CRISIS Home Resolution Treatment Team and reported a return of suicidal thoughts, he said that he felt he needed medication, counselling and mental health support. Mr Larsen agreed to be contacted by a Mental Health Practitioner from the Mental Health Central Access Point for the purposes of carrying out a triage.

On 5 January 2023, in the evening, a Nurse from the Mental Health Central Access Point contacted Mr Larsen to carry out a Safe and Well Call. During the call Mr Larsen confirmed that he was ok and agreed for the triage appointment to be carried out on 6 January 2023, confirming that he would be able to keep himself safe until then. It was accepted during the inquest by the Nurse who undertook this safe and well call that she had not read Mr Larsen's medical records or his referral document before making the safe and well call and therefore she was not aware of the risks relating to Mr Larsen when she made the call.

On 6 January 2023 Mr Larsen was found hanging at home by his wife, he died before the planned triage call could take place.

Concerns

1. **Multi-Disciplinary Team ("MDT") Meetings**

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

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.

2. <u>Risk assessments</u>

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*".

3. <u>Discharge</u>

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.

4. <u>The Serious Investigation and Reporting Process at LPT</u>

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.

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 August 08, 2024. 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 **The Larsen Family** I have also sent it to **The CQC** who may find it useful or of interest. 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: 13/06/2024**  **Miss I THISTLETHWAITE** **His Majesty's Assistant Coroner for Rutland and North Leicestershire**