Nottinghamshire Healthcare NHS Foundation Trust
Duncan Macmillan House
The Resource
Porchester Road
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Tel: [redacted]

20 May 2024

Private and Confidential
HM Assistant Coroner Amanda Bewley

Dear Miss Bewley

Regulation 28 Response: Mr. Alexander Lyalushko

I write in response to the inquest which was held from the 12th to the 15th March 2024 into the death of Mr Alexander Lyalushko. We accept your findings in relation to the received Regulation 28. We are very sorry that after the death of Alexander it later emerged that the GP had communicated with the Trust requesting engagement by the Local Mental Health team and furthermore that this was not attempted or known due to a technical issue and the letter not being responded to. We extend our apologies to the family of Alexander and for the distress this has caused as a result.

Please find below the Trust response and actions taken.

Inadequate Review and Incident Investigation Following a Death.

I would like to assure you that we take all deaths very seriously and seek to learn through a variety of methodologies. The methodologies are based on the initial fact find and review of the case records but also can be based on what service the patient was seen by and when the last contact occurred. Specifically, in relation to Alexander, I have been advised that the decision making was based on the understanding that he had been out of Trust services for approximately 9 months and at the time, there were no known concerns raised by his family at the time that either the Patient Safety, or Inquest Team were aware of. A Case Note Review (CNR) was therefore agreed to review his care and treatment and to identify any learning. A CNR requires the author to review the clinical record only.

We unfortunately recognised during preparation for the inquest that the GP for Alexander had made a referral in November 2022 and that this was not actioned. This referral was not in the Trust clinical

record and therefore unavailable to the author of the CNR. This information became known about in January 2024 and agreed that this would be dealt with via a statement from the relevant team leader. This statement was to confirm that this referral was not available or known to the author of the CNR, confirm what had occurred, confirm what should have happened according to procedure, and what had since been put in place to reduce risk of recurrence.

It was subsequently agreed at the inquest that a further review would be undertaken and addendum to the report added to take into account this information that was not known at the time of the original CNR, as well as the additional points raised within the findings and conclusion document provided to the Trust. This is being undertaken and nearing completion. We will share this once completed with you and the family of Alexander, who have been involved in the onward investigation process. Once completed we will be better sighted to understand the wider lessons learnt and actions required to mitigate future occurrence and ensure the correct oversight is deployed.

Moving forward, Nottinghamshire Healthcare NHS Trust are transitioning to the new Patient Safety Improvement Framework. As this transition progresses, the way in which we approach the review of care for deaths likely to be subject to inquest will change and we are working with HM Coroners to ensure that this transition is smooth and meets the needs of the Coronial enquiry.

I hope that the information contained within this response provides assurance to you and Mr. Lyalushko's family that we have heard and understood the concerns raised and continue in our journey to make improvements subsequent to this process for future patient care.

Yours sincerely

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Executive Director of Nursing, AHPs & Quality