East London
NHS Foundation Trust

Office of the Chief Medical Officer
Trust Headquarters
Robert Dolan House
5th Floor
9 Alie Street
London E1 8DE
[redacted]

Private & Confidential

HMC Nadia Persaud
[redacted]

Dated 30 June 2026

Dear Madam,

RE: REGULATION 28 REPORT

1. This is a formal response to your Regulation 28 report issued on 2 May 2026 where you set out concerns relating to the care of [redacted] under the East London NHS Foundation Trust's (the Trust's) care.

2. I understand that at the inquest into Mrs Bibi's death, you heard evidence from the Trust's Deputy Borough Director for Newham outlining the learning that has taken place because of her death. I understand that you remained concerned about the risk of future deaths in relation to the following areas:

> Concern 1 - There was no adequate evidence of a response to multiple attempts by the police to formulate a safety plan for the family
>
> Concern 2 - No advice was sought from the forensic psychiatric team in light of the previous conviction; nature of risk and assault on his mother in October 2020
>
> Concern 3 - No DASH risk assessment was completed or attempted, following incidents where family were harmed or threatened
>
> Concern 4 - No attempts to involve the safeguarding or social care team to protect vulnerable family members
>
> Concern 5 - No relapse prevention plan/risk management plan, drawn up with the input of the patient and family members
>
> Concern 6 - There was no risk assessment within the home environment with practical advice to the family on how to keep safe in the event of another violent relapse

3. I am writing to assure you and the family of Mrs Bibi that the Trust has carefully reviewed the issues highlighted within the Regulation 28 Report and has actioned as outlined below.

RESPONSE

Concern 1: Police communication

4. The key elements of communication between the Trust's Newham Mental Health Services and the Police include the Multi-Agency Interface Meeting and the Right Care Right Person meeting. Both meetings are held monthly. The Interface Meeting allows both MH Services and the police to raise concerns or address issues that have been relevant to the interface between mental health and criminal justice system. This has a set agenda and actions are recorded. The Right Care Right Person meeting is to address some of the changing practice and culture in the ways of working arising from the introduction of the Right Care Right Person approach.

5. Both provide forums for addressing interface challenges between mental health services (across health and social care teams) and the police, as well as for escalating individual cases where there are concerns about ensuring an appropriate response.

6. [redacted] is the Trust's Health, Safety and Security Lead. He provides a direct link to the Trust-wide Senior Police Liaison Meeting held quarterly. He can be contacted for any issues relating to liaison with the police, particularly where escalation may be required.

7. On 21 April 2026 communication was circulated Trust-wide including expectations around contacting the police.

Concern 2: Forensic input

8. The process for seeking forensic consultation has been re-affirmed and circulated. Very simply, referrals can be made directly to a forensic colleague via their secretary. Where the threshold for review or consultation is met, the forensic consultant will take this forward.

9. In 2023 the NE London integrated care board launched the FIND (Forensic Intellectual and Neurodevelopmental Disabilities) team. This would now be an additional consultative resource to support NE London teams working with service users with Learning Disability where there was a concern around potential contact with criminal justice services. Routes to access this resource has been circulated amongst staff.

10. The Trust is also convening a workshop on 14 July 2026 to review co-working and liaison arrangements between forensic and general adult mental health services to ensure good practice is shared, including to review which kinds of cases are appropriate to discuss. This will include representatives from all Trust geographical areas and all areas within North East London.

Concern 3: DASH risk assessment

11. All staff are required to complete Level 3 Safeguarding integrated Children/Adult training which covers DASH as an assessment tool. Refresher training is provided every three years. As of April 2026, the Newham directorate compliance levels are currently at 88% and 90% for Adult Level 3 and Children Level 3 training respectively.

12. Throughout May and June 2026, the Corporate Safeguarding Team has been delivering training for 60 Trust-wide Domestic Abuse Ambassadors. The training sessions aim to upskill operational staff members to act as a local point of expertise on Domestic Abuse best practice, with Named Professionals as the next point of contact for staff. The training focuses on DASH risk assessment as the tool for assessment. All Domestic Abuse Ambassadors will be provided with quarterly supervision delivered by Named Professionals.

13. In addition, the Corporate Safeguarding team shares Trust-wide learning from DHR (Domestic Homicide Review)/DARDRs (Domestic Abuse Related Death Review) by newsletter which identifies the use of the DASH as learning from deaths.

Concern 4: Safeguarding

14. Since this tragic incident, the Trust's Newham Mental Health Service has made great efforts to integrate our safeguarding work with Local Authority colleagues through the introduction and bolstering of joint forums where cases are reviewed and plans are agreed.

15. Named Professionals for Safeguarding provide case advice to clinicians when requested. Quarterly Safeguarding Supervision is delivered across the Trust. Inpatient mental health services have a fortnightly huddle and 4 weekly supervision with the Corporate Safeguarding Team.

Concern 5: Relapse prevention plan and risk management plan

16. The Trust has a large piece of work underway reviewing and strengthening risk assessment and management processes. This will involve changes to our clinical recording system as well as staff training. This is intended to create processes that are more focused on risk formulation, based on current factors and historical risk. For clarity, these processes would always be expected to involve the service user and also family/carers where this is relevant.

17. The Trust is also working to improve our work with carers which will be important in supporting carers where issues of risk are relevant. This will be a multi-year programme focused on the "Triangle of Care", in association with the Carer's Trust. For Year 1 (2026), our focus will be on establishing a clear baseline across Mental Health Inpatient and Crisis Services through the Triangle of Care self-assessment process, identifying areas of good practice and opportunities for improvement, and supporting directorates to develop local action plans.

18. It is important to note that relevant risks in this case would need multi-agency responses, whether through safeguarding or community safety pathways. This was discussed in the DARDR (Domestic Abuse Related Death Review) and continues to be an area of improvement work (discussed at inquest and in both ELFT learning statements, as per concerns 1, 3 and 4 above).

Concern 6: Risk assessment in home environment

19. In relation to the specific risks relating to this case, the relevant actions are those around risk formulation in terms of identifying risks (as per concern 5). In terms of mitigating identified risks, these should flow from the risk assessment and include the home environment where relevant. In relation to family or carer safety, the appropriate actions will predominantly relate to either safeguarding processes (DASH assessment/ MARAC referral etc) or community safety/police liaison processes. Learning for these is covered in relation to concerns 1, 3 and 4 as per the learning statements.

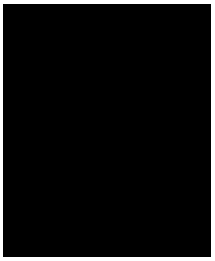
20. Other direct health based responses would be focused on treating the underlying mental health condition where this is relevant, as did happen in this case. The trust might support hazard management advice (eg: locking away sharps) as a temporary measure, perhaps in the context of awaiting court approval for a MHA assessment. However, this would not be practical or robust for either a long-term approach or to manage an acutely dangerous situation. Safeguarding/Community Safety approaches or involving the police would be the approved and expected routes respectively. These are clearly outlined to staff and feature prominently in regular advice to both service users and carers respectively.

Conclusion

21. I hope this response provides sufficient reassurances to you and to the family of Mrs Bibi about the additional learning that has taken place at the Trust because of her sad death.

I would like to offer my sincere and heart-felt condolences to her family at this difficult time.

Yours sincerely



Chief Medical Officer