Essex Partnership University
NHS Foundation Trust

Freedom of Information Request

Reference Number: EPUT.FOI.20.1479
Date Received: 04 March 2020

Information Requested:

I have seen various references to serious incidents that have occurred at Essex Partnership University Foundation Trust as written in the Mid and South Essex joint committee board papers. The excerpts are below:

Joint committee board paper Dec 2019, page 36
https://midessexccg.nhs.uk/about-us/mid-and-south-essex-joint-committee/committee-papers/2019/3501-full-part-i-jc-papers-6-12-19/file
There are currently 36 active serious incidents assigned to Essex Partnership University Foundation Trust (EPUT) Mid and South Essex Mental Health Services. Two Level 3 Independent Investigations are currently in progress.

Joint committee board paper Feb 2020, page 55
https://midessexccg.nhs.uk/about-us/mid-and-south-essex-joint-committee/committee-papers/2020/3661-full-part-i-jc-papers-27-2-20/file
There are currently 40 active SIs assigned to EPUT Mid and South Essex Mental Health Services. Two Level 3 Independent Investigations are currently in progress.

As allowed for under the Freedom of Information act please may I see:

1. Details of the "40 active serious incidents" that have been assigned to Essex Partnership University Foundation Trust, including an outline of what happened, the month/year in which it happened, the level of harm that occurred and what actions the trust is taking as a result.

2. Details of the "two Level 3 Independent Investigations are currently in progress" at Essex Partnership University Foundation Trust, including an outline of what happened, the month/year in which it happened, the level of harm that occurred and what actions the trust is taking as a result.

I do not need to see confidential patient information, so I do not need to know age, name or any other identifying features of the individuals involved.

Response:

1. Having reviewed the information quoted in this request there is a difference between the information EPUT provided to Mid and South Essex and the numbers quoted in their board papers. In January the Trust provided the CCG with a full quarterly quality report and quality exception report. This shows 39 Serious Incidents for the year to date. In February the Trust provided just the quality exception report and this showed 44 Serious Incidents for the year to date.

It is possible that when they met in February they only had the January reports at the time.

Therefore the Trust has provided details of the 39 serious incidents as requested, with the exception of those that have not been subject to inquest where the outcome was a death. This information is withheld under Section 41 of the Freedom of Information (Information provided in Confidence).

Degree of Harm:	Month/ Year:	Treatment Pathway:	Incident and location:	Actions taken:
Death	01/2019	Treatment in Community Mental Health Services	Patient jumped from height in a location known to them from childhood	1. Team made aware that they must adhere to CPA Policy re care planning. 2. MDT discussions to be documented in individual patient casenotes. 3. Staff made aware of Integrated Dual Diagnosis Policy.
Severe / Major (permanent or long term harm)	03/2019	Treatment in Mental Health In-Patient Services	Patient had a fall which resulted in a fractured left neck of femur – unwitnessed incident in bedroom	1. Ward manager discussed incident with staff in team meeting to ensure emergency ambulance is called when required. 2. Ward staff completed mandatory training in falls prevention.
Death	04/2019	Treatment in Community Mental Health Services	Patient was found hanging at their home address	1. Review of guidance and training available
Death	04/2019	Treatment in Community Mental Health Services	Patient was found hanging at their home address	1. Clinicians in Mental Health Liaison Teams and First Response Teams reminded of the need to complete a detailed record of patients' mental state even when patients decline a full assessment. 2. Clinicians advised to ensure that correct date of birth is recorded.
Severe / Major (permanent or long term harm)	04/2019	Treatment in Mental Health In-Patient Services	Patient had a fall which resulted in a fractured neck of femur – witnessed by staff in communal area of ward	1. Audit of MEWS charts. 2. Protocol put in place to ensure ward activities are risk assessed. 3. Assessment of suitable footwear to be completed prior to taking part in activities.

Death	04/2019	Treatment in Community Mental Health Services	Patient was found hanging at their home address	1. Staff reminded to check next of kin details at initial assessment. 2. Senior Access & Assessment staff to ensure process for requesting medical advice and/or review is followed.
Death	05/2019	Treatment in Community Mental Health Services	Patient was found hanging at their home address	1. Matron to review and consider how patients, families and carers are involved in decision regarding discharge planning. 2. Medical staff to adhere to EPUT guidelines for the Safe & Secure Handling of Medicines. 3. Staff must clearly identify service contact details for patients. 4. Staff to provide verbal handover as well as electronic in high risk cases. 5. CRHT staff to ensure they capture patients' views and consent with regard to referral to other services.
Death	05/2019	Treatment in Community Mental Health Services	Patient died at home following an intentional overdose of prescribed medication	1. Communication to Outpatient doctors reminding them of their responsibility to document assessments, diagnosis, formulation and any prescriptions given accurately and in a timely manner.
Death	06/2019	Treatment in Community Mental Health Services	Patient died at home following an overdose of prescribed medication	1. Community mental health staff reminded of CPA policy and to ensure that they are up to date with training.
Death	07/2019	Treatment in Community Mental Health Services	Patient died following an overdose of prescribed medication, taken at home	1. Staff to adhere to EPUT Suicide Prevention Clinical Guideline – shared and discussed in team meetings and individual supervision. 2. Staff to adhere to EPUT Clinical Risk Assessment & Safety Management Policy –shared and discussed in team meetings and individual supervision. 3. Staff to adhere to EPUT CPA Policy and Procedure. 4. MDT discussion must be documented on individual patients' electronic database. 5. Team members to be directed to

				the IAPT Operational Policy Section 7 and the Head of IAPT to share this learning point via the team meeting and supervision. 6. This is to include discussion and reminder of the process regarding discharge from service i.e. the call back process and process of sending a letter to the patient's home address and GP if the patient fails to attend an appointment. 7. The use of text messages in this capacity is to be reviewed at an organisational level and further actions taken forward as applicable. 8. RCA to be shared with GP. 9. Review of triage process to ensure appropriate MDT input into decision making. 10. Staff to adhere to EPUT Suicide Prevention Clinical Guideline – shared and discussed in team meetings and individual supervision. 11. Staff to adhere to EPUT Clinical Risk Assessment & Safety Management Policy –shared and discussed in team meetings and individual supervision. 12. Staff to adhere to EPUT Suicide Prevention Clinical Guideline – shared and discussed in team meetings and individual supervision. 13. Staff to adhere to EPUT Clinical Risk Assessment & Safety Management Policy –shared and discussed in team meetings and individual supervision.
Death	07/2019	Treatment in Community Mental Health Services	Patient died after jumping from height from a public building	1. During the Business Meeting, clinicians reminded of the CPA process as per guideline from the CLP30/CLPG30 and to ensure patients care needs are address accordingly through the CPA framework. 2. Informal teaching session for staff to revisit Section 117

				requirement in regards to aftercare arrangements 3. The team Manager and Leads will develop processes and arrangements in regards to how MDT discussions and management plans are formulated and recorded into the Patient Electronic Record (Mobius). 4. Ward admin/clerk reminded of the need to ensure In-patient Consultant Secretary are notified of discharges from the wards. 5. Ward admin/clerk to ensure that Community Consultants informed of discharges from the ward by forwarding them with the appropriate notification form and link on Mobius. 6. Medical Secretaries to Inpatient Consultants monitor the completion of Discharge Summary and inform the Consultants if there are any issues with delay. 7. Medical Secretaries to Inpatient Consultants forward Discharge Summary in a timely way to the Community Consultants in order for follow-up review in the out-patient clinic to be set up. 8. The treating team in the community will be reminded through the next Business Meeting about how they can engage patients in care plan in regards to challenges such as poor concordance.
Moderate (short term harm - required further treatment, or procedure)	07/2019	Treatment in Community Mental Health Services	Patient was admitted to intensive care following an overdose and attempted hanging at home	1. The face-to-face FLO training package will be reviewed to ensure that it includes guidance on ascertaining capacity prior to sending the Duty of Candour letter. The guidance within the FLO contact record template will also be updated to reflect this. 2. The FLO training programme to be rolled out as scheduled across the Trust and a contemporaneous

				record of trained FLOs is to be maintained within the Incident Management Team to share with managers when appointing FLOs. The list of previous FLOs is to be reviewed to ensure they are offered enrolment onto the FLO training if they have not already completed it. 3. Service Manager to re issue the EPUT's CG24 Discharge and Transfer Clinical Guideline with reference to sections 6.0; 18.0; 20.0 and 25.0 4. The Recovery and Wellbeing Teams in their team meetings to discuss the EPUT's CG24 Discharge and Transfer Clinical Guideline with reference to sections 6.0; 18.0; 20.0 and 25.0 and to use the findings of report in their discussions and note the learning lessons. 5. Operational policy to be recirculated to MDT on Assessment unit 6. Operational policy to be agreed by Clinical Governance committee
Death	08/2019	Treatment in Community Mental Health Services	Patient died in hospital as a result of ingesting Sodium Nitrate	1. Clinicians to ensure patient information pack is provided at point of acceptance onto pathway 2. Clinical Manager and FEP lead to review and update current patient pack 3. The whole team to continue attending training and developments offered via NHS East of England EIP Network. The Clinical lead for the team monitor the training need of individual staff and progress is further monitored through individual supervision and appraisal 4. Medical training and development is monitored through the Clinical Director 5. A reflective session to be held with staff to review this additional learning and discuss the team's approach to actively involving

				families and carers into a patient's care where it has been consented by the patient. 6. Clinicians to ensure all documentation is supported by a dated covering letter 7. Investigation report to be shared with FEP staff. 8. Teaching to be arranged with independent Consultant Psychiatrist to include diagnostic criteria, symptomatology and NICE guidance in management of FEP patients 9. For the team to meet on a fortnightly basis to have group supervision and discuss specific cases alongside individual supervision arrangements 10. For the team to meet on a fortnightly basis to have group supervision and discuss specific cases alongside individual supervision arrangements
Death	08/2019	Treatment in Community Mental Health Services	Patient was found hanging at home	1. The Team manager will discuss with staff in the next Business meeting of the need to appraise and review all previous documentation available on Patient Electronic Records before reviewing/assessing patients who have been known to the mental health services in the past. 2. Service Manager will discuss with Mobius Team about the feasibility of developing trending assessment form within the patient's electronic record. 3. The Matron for the Home Treatment Team and Assessment Unit will re-iterate to staff within their teams via a Memo about the importance of cc emails to Team Lead and Manager of the

				Community Mental Health Services when urgent issues are raised in emails to care co-originator. 4. The Team manager will brought it to the attention of staff in the next Business meeting of the importance of engaging with the Next of Kin or Carers in order to gain further information and concerns that they may have where it's appropriate.
Death	08/2019	Treatment in Community Mental Health Services	Patient stepped in front of a train	No actions identified.
Death	11/2019	Treatment in Community Mental Health Services	Patient was found hanging at home	1. Clinical Director for General Adult Community to circulate the learning of this investigation and send a reminder of this requirement to medical staff 2. For SE CRHTT & SE First Response Teams to be reissued with Clinical Guideline-Suicide Prevention (CG29) & Clinical Risk assessment and safety management policy (CLP28) and that this is discussed and noted in their team meetings. 3. For a reminder to be sent all clinical staff in CRHTT & First Response Team that risk assessments should be viewed as dynamic and multi-dimensional to involve others in the care and treatment pathway. 4. SE Essex CRHTT & First Response Teams to be reminded of the practice guidance for coordinating care for patients outlined in the CPA Policy & procedures (CLPG30 & CLP30) 5. Clinical Director for General Adult Community to reinforce to clinical staff the importance of including diagnosis within clinical letters. 6. Serious Incident Team to share learning with the Electronic Systems Manager to review visuals of diagnosis within Mobius records.

				7. For SE CRHTT & SE First Response Teams to be reissued with Clinical Guidelines for Community Mental health Service Users Disengaging or non-Concordant with Current Prescribed Treatment Plans 8. And that this is discussed and noted in their team meetings. 9. The SE CRHTT & SE First Response Teams to be reminded that: if a patient is to be transferred from one community team to another this decision must be planned, communicated with explicit dates for transfer to ensure continuation of care and follows the principles of Care Programme Approach (CPA) the requirements around safe and effective transfer of care as outlined in the Trust CPA Policy and the CPA handbook. 10. The Service Manager community MH SE Essex to liaise with for the Discharge and Transfer Clinical Guideline (CG24 section 9) to be considered for review and further guidance given on transfers between Community MH services to support the 'Trusted assessor' approach when onward internal transfers between services are made.
Death	09/2019	Treatment in Community Mental Health Services	Patient was found hanging at home	1. All staff completing Risk Assessment must record the level of risk in the Assessment document and in case recording. 2. Staff to record all attendees of MDT in the MDT sheet. 3. All staff to record in the MDT sheet when a RAG rating is lowered from Red to Green with a comprehensive rationale recorded in the documentation. 4. All staff to ensure that the rationale for discharge from any service within EPUT must be comprehensive and recorded on the EPUT electronic Systems. 5. All staff is to ensure that every home visits undertaken is

				documented into the EPUT electronic systems. 6. When there are difficulties in uploading any documentation, IT must be contacted as soon as practical and contemporaneous notes of the home visit must be completed and later uploaded. 7. When a patient meets the criteria for any psychotherapy referral, staff are to ensure this is followed up and recorded in the patients documentation. 8. Every patient assessed by CRHTT/HFT staff should be discussed in MDT and a record of discussion should be documented. 9. Where a patient presents with any symptoms of psychosis, staff must consider the possibility of a psychotic illness. The case should be discussed in MDT/handover and recorded in documentation the rationale as to why the patient does or does not fit that criteria.
Severe / Major (permanent or long term harm)	10/2019	Treatment in Mental Health In-Patient Services	Patient had a fall which resulted in a fractured neck of femur – the fall was unwitnessed in the patient's bedroom on the ward	1. Staff to ensure FRAT is completed within 24 hours of admission. 2. Staff are to document if a patient has refused postural blood pressure and to ensure that future attempts are made and documented. 3. Staff are to document if a patient has refused postural blood pressure and to ensure future attempts are made and documented.
Death	12/2019	Treatment in Community Mental Health Services	Patient was found deceased in a church yard by a member of the public	1. A representative from SMHT to attend multi-agency meetings regularly and feedback to team in business meeting
Moderate (short term harm - required further	12/2019	Treatment in Mental Health In-Patient Services	Patient inserted pins into her arm, whilst an inpatient on a MH ward	1. Ward staff to adhere to the EPUT Search Policy. 2. Ward staff to be reminded that they must be vigilant when passing letters/parcels on to

treatment, or procedure)				patients to prevent contraband items being sent to the ward. 3. Individual patients who are assessed as being at high risk of receiving contraband items must have a care plan relating to the management of this risk.
Severe / Major (permanent or long term harm)	12/2019	Treatment in Community Mental Health Services	Patient was taken to hospital and needed intensive care as a result of drinking drain cleaner – the incident occurred in the patients home	No actions identified.
Moderate (short term harm - required further treatment, or procedure)	12/2019	Treatment in Mental Health In-Patient Services	Patient had a fall which resulted in a fractured neck of femur. The fall was witnessed by staff in the dining area of the ward	Investigation on-going
Low / Minor (minimal harm - required extra observation or minor treatment)	12/2019	Treatment in Community Mental Health Services	Patient was arrested for stabbing another resident in the back at their care home.	Investigation on-going

2. **Level 3 Investigations:**

   a. Incident 1 – System wide independent investigation commissioned by NHS England into a homicide committed by a patient under the care of SEPT in May 2016. This investigation has not yet completed and therefore actions not yet identified by the independent investigators.
   b. Incident 2 - This case was due to be heard at Inquest in April 2020 but this has now been adjourned due to Covid-19

Applied Exemption:

Section 41 (Information provided in confidence):

(1) Information is exempt information if—

(a) it was obtained by the public authority from any other person (including another public authority), and

(b) the disclosure of the information to the public (otherwise than under this Act) by the public authority holding it would constitute a breach of confidence actionable by that or any other person.

(2) The duty to confirm or deny does not arise if, or to the extent that, the confirmation or denial that would have to be given to comply with section 1(1)(a) would (apart from this Act) constitute an actionable breach of confidence.

Publication Scheme:

As part of the Freedom of Information Act all public organisations are required to proactively publish certain classes of information on a Publication Scheme. A publication scheme is a guide to the information that is held by the organisation. EPUT's Publication Scheme is located on its Website at the following link https://eput.nhs.uk