		Agenda Item No: 6i
SUMMARY REPORT	**Executive Safety Oversight Group**	**29 March 2022**

Report Title:	**Coroner Recommendations within the Scope of the Independent Inquiry**					
Executive/ Non-Executive Lead:	Nigel Leonard, Executive Director of Major Projects and Programmes					
Report Author(s):	Gill Brice, Project Director					
Report discussed previously at:	N/a					
Level of Assurance:	**Level 1**	✓	**Level 2**		**Level 3**	

Risk Assessment of Report – *mandatory section*		
Summary of risks highlighted in this report	If EPUT is not open, transparent and have the correct governance arrangements in place then it may not deal with the consequences of past failings resulting in undermining our Safety First, Safety Always Strategy.	
Which of the Strategic risk(s) does this report relates to:	SR1 Safety	✓
	SR2 People (workforce)	✓
	SR3 Systems and Processes/ Infrastructure	✓
	SR4 Demand/ Capacity	
	SR5 Essex Mental Health Independent Inquiry	✓
	SR6 Cyber Attack	
Does this report mitigate the Strategic risk(s)?	Yes	
Are you recommending a new risk for the EPUT Strategic or Corporate Risk Register? *Note: Strategic risks are underpinned by a Strategy and are longer-term*	No	
If Yes, describe the risk to EPUT's organisational objectives and highlight if this is an escalation from another EPUT risk register.	N/a	
Describe what measures will you use to monitor mitigation of the risk	A BAF action plan is in place.	

Purpose of the Report		
This report provides the Executive Safety Oversight Group: • With an overview of Coroner recommendations, which fall within the scope of the Essex Mental Health Independent Inquiry. The report also provides an overview of the Trust actions and responses to Coroner Recommendations.	**Approval**	
	Discussion	✓
	Information	✓

Recommendations/Action Required

The Executive Safety Oversight Group is asked to:

1 Note the content of this report.
2 Consider the themes from the Coroner recommendations and decide if any further analysis work on current Coroner recommendation themes should be undertaken by the relevant department.
3 Consider if there are any training requirements arising from the top themes

Summary of Key Issues

The key items to note are as follows:

- From 1 January 2000 to 31 December 2020 there are 13 deaths within the scope of the Essex Mental Health Independent Inquiry where the Coroner issued a Prevention of Future Death/ (PFD) or Rule 43 report at the inquest.
- Of the 13 Prevention of Future Death/Rule 43 Reports, 4 were issued to SEPT, 6 to NEP and 3 to EPUT.
- Of the 4 SEPT reports, 3 related to patients who were admitted to Basildon Mental Health Unit.
- Of the 6 NEP reports, 2 were in relation to the Linden Centre and 2 were in relation to The Lakes.
- Of the 3 EPUT reports, 1 was in relation to The Lakes, 1 in relation to the Linden Centre and 1 in relation to Rochford Hospital.
- Of the 13 Coroner PFD/Rule 43 Reports, 3 related to deaths in 2015 (2 NEP, 1 SEPT)
- Of the 13 Coroner PFD/Rule 43 Reports, 12 related to suicide and 1 related to a fall.

Relationship to Trust Strategic Objectives	
SO1: We will deliver safe, high quality integrated care services	✓
SO2: We will enable each other to be the best that we can	✓
SO3: We will work together with our partners to make our services better	✓
SO4: We will help our communities to thrive	✓

Which of the Trust Values are Being Delivered	
1: We care	✓
2: We learn	✓
3: We empower	✓

Corporate Impact Assessment or Board Statements for Trust: Assurance(s) against:			
Impact on CQC Regulation Standards, Commissioning Contracts, new Trust Annual Plan & Objectives			✓
Data quality issues			
Involvement of Service Users/Healthwatch			
Communication and consultation with stakeholders required			
Service impact/health improvement gains			✓
Financial implications			
Governance implications			
Impact on patient safety/quality			✓
Impact on equality and diversity			
Equality Impact Assessment (EIA) Completed	**NO**	**If YES, EIA Score**	N/a

Acronyms/Terms Used in the Report			

Supporting Documents and/or Further Reading

Lead

[redacted]

Nigel Leonard
Executive Director of Major Projects and Programmes

Agenda Item 6i
Executive Safety Oversight Group
29 March 2022

EPUT

Coroner Recommendations within the Scope of the Independent Inquiry

1 Purpose of Report

The purpose of this report is to provide an overview of Coroner recommendations, which fall within the scope of the Essex Mental Health Independent Inquiry. The report also provides an overview of the Trust actions and responses to Coroner Recommendations.

2 Executive Summary

2.1. Number of Coroner Recommendations

At the time of writing this report there are 13 deaths within the scope of the Essex Mental Health Independent Inquiry where the Coroner issued a Prevention of Future Death/ (PFD) or Rule 43 report at the inquest. These patients died within 3 months of a Mental Health Ward inpatient stay between 1 January 2000 – 31st December 2020.

The Project Team continue to search for Coroner recommendations. It is also worth noting that seven deaths are pending an inquest date.

2.2. Breakdown of Coroner Recommendations

The table below breaks down the number of PFD/Rule 43 Reports by Date of Death, Trust, Location, Circumstances of Death, Coroner Conclusion and Date of PFD/Rule 43 Report:

Date of Death	Trust	Hospital	Ward	Circumstance Method	Coroner Conclusion	Date of Rule 43/PFD Report
23/01/2008	SEPT	Basildon MHU	Assessment Unit	Overdose	Killed herself whilst suffering from a diagnosed mental illness	22/11/2011
27/06/2019	EPUT	The Lakes	Peter Bruff	Hanging	Suicide	24/11/2020
29/03/2008	SEPT	Basildon MHU	Assessment Unit	Jumped from Multi Storey	Took own life impulsively whilst balance of mind was disturbed, due to a diagnosed bipolar disorder of a rapid cycling variety	18/03/2010

25/01/2016	NEP	St Margaret's	Kitwood, St Margaret's	Died following a fall	Narrative - suffered a number of falls and last fall may have contributed to death - failings in implementation of NEP Prevention and Management of Falls Policy on Kitwood Ward	19/08/2016
23/03/2015	NEP	The Lakes	Gosfield	Hanging	Suicide - jury concluded there was a failure to provide a safe environment at the unit and this, in conjunction with ineffective communication, more than minimally contributed to her death.	29/03/2016
15/11/2012	NEP	Linden Centre	Galleywood	Hanging	Open narrative - subject tp a series of multiple failings and missed opportunities over a prolonged period of time by those entrusted with his care. The jury found that relevant policies and procedures were not adhered to impacting on overall care and well-being leading up to his death.	01/06/2015
21/05/2015	NEP	Linden Centre	Finchingfield	Hanging	Narrative - The state failed to protect life evidenced by the following: 1. Risk of suicide was not properly and adequately assessed and reviewed i.e. • Transfer of verbal and written information • Risk assessment • Quality of observation 2. Adequate and appropriate precautions were not taken to manage risk of suicide i.e. • Search policy at the time of the incident • Quality of observation • Current policies at	16/06/2017

					the time and previous recommendations of risk and environmental factors were not implemented adequately	
02/03/2016	NEP	Derwent Centre	Chelmer, Derwent	Suffocation	Suicide - jury concluded that risk of self harm/suicide was not properly and adequately assessed and reviewed. Adequate and appropriate precautions were not taken to manage her risk of self harm/suicide.	11/11/2016
20/05/2015	SEPT	Basildon MHU	OlderMH - Basildon - Gloucester	Hanging	Narrative Conclusion - killed himself whilst suffering from depression. Risk of self-harm/suicide was not properly and adequately assessed and reviewed.	03/11/2015
12/04/2017	EPUT	Linden Centre	Finchingfield	Train	Suicide	19/09/2017
12/02/2018	EPUT	Rochford	ChildMH - Rochford - Poplar	Hanging	Suicide - Numerous failings of the state to protect her life contributed to her death.	09/08/2018
18/01/2013	NEP	The Lakes	Harbour Suite	Hanging	Killed herself whilst suffering from a diagnosed mental illness	25/06/2014
10/09/2011	SEPT	Basildon MHU	Assessment Unit - Basildon	Alcohol and gamma-hydroxybutyrate poisoning	Suicide	21/02/2013

Of the 13 Prevention of Future Death/Rule 43 Reports, 4 were issued to SEPT, 6 to NEP and 3 to EPUT. Of the 4 SEPT reports, 3 related to patients who were admitted to Basildon Mental Health Unit. Of the 6 NEP reports, 2 were in relation to the Linden Centre and 2 were in relation to The Lakes. Of the 3 EPUT reports, 1 was in relation to The Lakes, 1 in relation to the Linden Centre and 1 in relation to Rochford Hospital.

Of the 13 Coroner PFD/Rule 43 Reports, 3 related to deaths in 2015 (2 NEP, 1 SEPT), 2 related to deaths in 2008 (both SEPT) and 2 related to deaths in 2016 (both NEP). There was a PFD/Rule 43 Report for 1 death in each year of 2011, 2012, 2013, 2017, 2018, and 2019 with no PFD/Rule 34 reports relating to deaths between 2000-2007, 2009-2010 and 2014. Whilst there have been no PFD /Rule 43 Reports for the year 2020, as noted in section 2.1, 7 deaths between 2019-2021 are still awaiting inquest hearings and therefore this figure could change.

Of the 13 Coroner PFD/Rule 43 Reports, 12 related to suicide and 1 related to a fall.

2.3. Individual Coroner Concerns and Trust Response/Actions:

The table bellows shows the Coroner concerns raised within each PFD/Rule 43 Report and the correlating Trust Response/Actions:

Coroner Concern	Trust Response/Action
Record keeping	Auditing of records Supervision – sample of records reviewed Mandatory training around record keeping
Communication between teams	Physical relocation of teams New and updated policy around communication
Inadequate timing of Mental Health Act Assessment	Referrals for urgent MHA assessments accompanied by phone call between teams – risks to be made explicit so that management of risk can be agreed
Communication between teams	Referrals for urgent MHA assessments accompanied by phone call between teams - risks to be made explicit so that management of risk can be agreed
No effective care plan/contingency plan to meet obvious suicide risks	Revised policies and strengthened training for staff around risk and suicide prevention. Supervisions and audits in place to identify training needs.
Inappropriate discharge – mental state was not stabilised, medication was not recommenced and Consultant/Care Co-ordinator not involved in decision to discharge	Clear instructions given to staff around appropriate discharges. Developed approach to evidence based practice. Text messaging protocol introduced giving guidance- to staff about the system for improving communication between professionals and managing risk for patients admitted, to the assessment unit.
Inadequate treatment/assessment	Strengthened systems in place for monitoring the implementation of NICE guidance through the revision of clinical governance structures and the appointment of a NICE Lead. Clinical guidelines developed to meet standards in the NICE guidance.

Information from Mental Health professionals and those responsible for care not sought	Operational Policy reviewed and enhanced in relation to handover of care Administration manual revised and updated in relation to handling messages Crisis Cards given to all patients and carers/families
Information from deceased's family not sought	Clinical teams engage with patients to indicate the benefits of involving family members in their care and treatment - this discussion is recorded in the clinical records. CPA Policy Handbook reviewed to include a set standard by which carers must be offered a carers assessment. 'Looking After Me' course for carers offered to all carers
Appropriate information relating to Bipolar and recognising risks was not imparted by staff to the deceased family/carers	Staff involved in developing the Care Programme Approach revisions and reminded of their responsibilities in this area. Developed a Being Open policy in line with national guidance Information about Bipolar Disorder made available to staff to provide to family/carers. Access to information is available at kiosks and via the intranet.
Failure to respond to non-attendances with Mental Health Team	Policy which provides clear guidance for staff about actions to take when a service user is unwilling to engage with services
Failure to ensure staff were aware of and followed appropriate procedures to ensure provision of adequate cover for staff sickness	Common buddy system protocol implemented. Formal audit undertaken to review compliance
Lack of any effective system of risk management	Development of risk assessment and risk formulation training - compliance with this is monitored through management and clinical supervision processes and regular audits of clinical records. Developed a risk conciliation tool which is designed to pull together and document historical and current risk from various sources.

Poor record keeping and auditing	Project Group is overseeing the introduction of an electronic Integrated Patient Record which will be easily accessible to relevant staff at all times. S Sample of records reviewed at each supervision session to ensure record keeping standards are achieved and maintained. General audits of patient records form part of our Trust audit plan. In addition, Service Directors undertake regular random checks of sample patient records. Individual Consultant Psychiatrists also undertake spot audits of records as well as re-viewing these as part of their roles as Clinical Tutors in their supervision of junior doctors.
Failure to implement Falls Policy	New policy devised which has one comprehensive risk assessment for falls. Full training package introduced for all staff and audits introduced.
Outcome of review meeting not signed off or communicated to patient	Ward review pro-forma reviewed to ensure all decisions are discussed at MDT and documented. Pro-forma clearly identifies decision of the ward review with documented agreement/signatures of those in attendance. Trust will be moving to electronic patient records for accessibility between teams and continuity of care.
Inadequate staffing levels	Staffing levels reported monthly and monitored at Public Board meetings.
Multiple failings and missed opportunities over a prolonged period of time – including failure to follow relevant policies and procedures	Trust considered Coroner's suggestion of holding an Independent Inquiry but made a formal decision not to commission. Decision was shared with family of the deceased.
Risk of suicide not adequately assessed/reviewed	Learning has been shared across the Trust and family asked to comment on drafting of new policy
Inadequate search policy	Changes to policy made which includes training for staff and review of policies from other MH Trusts
Risk of suicide not adequately assessed/reviewed	Review of processes/policy and training given to staff
Inadequate SI action plan	Completed and updated action plan provided with evidence

Risk of suicide was not adequately assessed/reviewed – no named nurse allocated	Variety of checks now carried out through supervision and meetings. Allocation of new admissions now monitored by senior nurse on ward and reported to matron with records. Risk assessments are reviewed and monitored at each ward round. Electronic risk assessments and care plans now in place. Learning from incident shared across Trust.
Lack of a 'patient champion' who has overall responsibility from admission to follow up in the Community.	Contact made with family to discuss idea further – Trust agreed with family to extend and develop the role of the care-coordinator
Assurance needed around decision to return shoelaces to patient	Policies and procedures around clinical decision making reviewed and updated regularly to follow national guidance and learning.
Physical surroundings on ward and use of mobile phones on ward	Meeting with family and patients planned to discuss surroundings and mobile phone protocol. Family to review proposed changes to ward environment and protocol around mobile phones to improve patient experience.
Recognition and notification of patients referred to the service via their GP or A&E	Processes for referrals and support from both GP and A&E outlined. More robust system in place to ensure appropriate follow-up. Introduction of new risk rating. Increased regular team meetings in place and discussions noted in records. Regular supervisions with staff. Buddy system in place for all patients.

2.4. Themes and Trends

Within the 13 PFD/Rule 43 Reports, the Coroner raised 27 Concerns. These are categorised as follows:

Concern Category/Theme	Number of Concerns
Risk Management/Assessments	6
Communication	6

Failure to follow or inadequate policy/procedure	3
Record keeping	2
Staffing Issues/Training	2
Clinical Decision Making	1
Inadequate Care Plan	1
Inadequate Discharge	1
Failure to respond to non-attendance	1
Inadequate Serious Incident Action Plan	1
Environment	1
Referral Process	1
Other	1
Total	**27**

The majority of concerns raised were around managing/assessing the risk of suicide for patients as well as communication between teams and the patient/family/carers.

Of the 27 concerns raised, 54 responses/actions were provided within a Trust response letter to the Coroner. The table below shows the category of Trust response/actions:

Response/Action Category	Number of Responses/Actions
New/Updated Policy or Procedure	12
Supervisions	7
Change of Procedure/Protocol	7
Training for staff	6
Audits	6
New clinical guidance/form or record	6
Learning shared across Trust	2
Appointment of new staff/change in role	2
Updated Action Plan	1
Other	5
Total	**54**

The majority of responses/actions resulted in a new or updated Trust Policy or Procedure. A number of actions also resulted in monitoring via staff supervisions, a change of procedure of protocol, training for staff, auditing or a new clinical form/record or guidance.

It is worth noting that one Coroner concern related to a death at the Linden Centre in 2015. The Coroner advised that it would be appropriate and helpful for NEP to facilitate an independent inquiry in to the circumstances surrounding the death. The Trust sought legal advice and advised the Coroner that they had made a formal decision not to commission a public inquiry at that moment in time. The Trust confirmed to the Coroner that this decision had been communicated with the family of the deceased at that time.

It is also worth noting that the Trust consulted with three families during their responses/actions taken following the Coroner's PFD/Rule 43 reports. These were in relation to drafting a new policy, changing the ward environment and developing the role of the care-coordinator.

3 Action Required

The Executive Safety Oversight Group is asked to:

1. Note the content of this report.
2. Consider the themes from the Coroner recommendations and decide if any further analysis work on current Coroner recommendation themes should be undertaken by the relevant department.
3. Consider if there are any training requirements arising from the top themes

Report prepared by
[redacted]

On behalf of
Nigel Leonard, Executive Director of Major Projects and Programmes