NHS
Essex Partnership University
NHS Foundation Trust

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Ms Geraldine Strathdee
Chair
Essex Mental Health Independent Inquiry
By Email: contact@emhii.og.uk

Dear Geraldine

Thank you for providing a copy of your embargoed open letter ahead of publication last week. I am writing to share my reflections and make suggestions to improve the working relationship between our two teams, as well as engagement with staff, to improve the prospects for the Independent Inquiry's success.

I share your disappointment that you have concluded that the Inquiry cannot fulfil its Terms of Reference. When we met in early 2021 I was encouraged by both the rigour of your approach in service of the families, and your desire to support Mental Health services in Essex, and nationally, to improve.

EPUT Preparations for the Inquiry

Whilst EPUT is not a commissioner, nor the sole provider of Mental Health services in Essex, the Board nonetheless understood that it was our services that would be under most scrutiny. The Trust Board took, and continues to take, its responsibilities to serve the Inquiry seriously.

We were aware that the scope of the Inquiry was very wide and we put in place measures to ensure we were in the best position to serve the Inquiry. In doing so we considered the provision of information in an open and transparent way to be paramount.

In service of this we put in place the following practical measures and governance:

- Established a dedicated department to programme manage the provision of information and liaison with the Inquiry. This includes an Executive Director Senior Responsible Owner (SRO).
- We appointed an Independent Director, and Independent Clinical Advisor, to scrutinise our processes and decision-making. The Independent Director reports to our Audit Committee.
- The Board agreed a set of principles (Appendix 1), in March 2021, to which the Executive would serve the Inquiry. In essence these were to be open, transparent and candid. The Board receive regular updates from the Executive SRO and the Audit Committee provides assurance.

- We have appointed an experienced legal team to advise us. This is to ensure we meet the principles agreed by the Trust Board.
- We made arrangements to support families and staff who were distressed by the Inquiry.

I believe, after consulting widely, that we have put in place extremely strong arrangements to serve the Inquiry.

Provision of Information

Identification of Deaths in Scope

The open letter contains implied criticism of the Trust's processes and provision of information. For the record, I set out the circumstances below.

As anticipated, with the scope of the Inquiry being so broad, establishing a way of providing all the data on deaths in Mental Health services over the last 21 years has been very challenging. We have multiple legacy organisations, and multiple electronic and paper records to interrogate. Mental Health services, and the standards of record keeping, have also materially changed over the 21 years.

In order to keep a good audit trail, and to remain transparent, we put in place a search methodology that we shared with your team and kept them regularly up to date. This highlighted not only the difficulties in both identifying deaths in our service, but also establishing the cause of death. These difficulties were particularly prevalent when trying to establish the information in the early part of the 21-year period.

Our initial work found that approximately 1500 people died over the 21-year timeframe whilst being in the care of Mental Health services in Essex. This number included unexpected deaths (in adult services and CAMHS), deaths from natural causes and deaths where the cause of death was unknown or not found in the records.

The unexpected deaths were clearly those that would need to be where the Inquiry would focus its attention.

Deaths with an unknown cause could have arisen from variable historical record keeping standards or because the individual died in a setting away from Mental Health services. For example, if someone had suffered a heart attack and was transferred to an acute service and subsequently died or, where an individual was transferred to out of area Mental Health services, the cause of death may not have been recorded in the Trust's Mental Health systems.

Throughout, we have remained conscious of our responsibility to adhere to the principles set out by the Board and our responsibility under Duty of Candour. We did not want the Inquiry to be undermined if people came forward where we had not correctly identified that the death of their loved one fell inside the scope of the Inquiry. We have been committed to ensuring that the Inquiry has information which is as accurate as we can provide. The Trust's project team has continued to validate the unknown causes of death and has kept the Inquiry team up to date on progress via a full reconciliation. This was an extremely time consuming and resource-intensive process of researching medical records in different forms and from different sources.

It was during this process of validation that we discovered that an oracle computer file containing information from 2000 – 2010 that should have been uploaded during a system

change in 2013 was not completed. This meant that our current information system, Paris, did not contain a complete history when our original report was run to identify the number of deaths within the scope of the Inquiry (circa 1500). This was not known to current staff in EPUT and was not visible in our initial research. This resulted in the total number of deaths to be investigated increasing by c.500.

Any limitations to the searches are a consequence of the nature of the records and historical practices in former organisations. Staffing and resource has not been an issue in limiting the thoroughness of searches requested by the Inquiry.

I am confident that this could not have been foreseen and it was discovered by the diligence of our search processes. Whilst I can see that this is extremely difficult for the Inquiry, I am equally confident that the information was disclosed appropriately.

Use of Data

The headline number of c. 1,500 or c. 2,000 deaths used in publicity by the Inquiry is, in my opinion, not a fair reflection of the deaths that would be of interest to the Inquiry. As you are aware, the number that can be currently attributed to unexpected deaths including suicide is c.500. The remaining numbers relate to deaths where the cause is unknown or not found, deaths which have, through the cross checking other records, later identified as being from natural causes.

I am aware that you have been supplied with independent research from the National Confidential Inquiry into Suicide and Safety in Mental Health (NCISH) that shows that the number of deaths by suicide in Essex Mental Health services was comparable to the rest of the country. The source of this research is highly credible and covers a comparable period of time to which the Inquiry is investigating. A summary report is contained in Appendix 2 for your reference.

Whilst I understand the need to raise the profile of the Inquiry I am concerned that the use of numbers that include deaths from natural causes and where the cause of death is unknown, creates an impression of disproportionate deaths in Essex. As far as I am aware this is simply not the case. This impression can have a detrimental impact on the confidence of current patients, their families and current (and future) staff.

The Provision of Additional Information

During 2022, the Inquiry requested further information of patients who are alive (e.g. Sexual safety incidents). This is extremely sensitive data that is, rightly, subject to legal restrictions in order to protect individuals. We took legal advice, including Counsel's opinion, and were not able to satisfy ourselves that we could legally supply you with the information, without further safeguards. We provided a number of routes that would allow us to safely and lawfully transfer the data to the Inquiry but this would have meant there would have been restrictions on how the Inquiry could use, and publish, the data.

I am pleased that the outstanding Information Sharing Protocol requested by the Trust some months ago is now being put in place as we see this as a mechanism to transfer the information required by the Inquiry quickly, safely and without delay.

Memorandum of Understanding

In November 2021, the Inquiry advised that they thought it would be helpful to have a Memorandum of Understanding (MOU), which sets out how the Inquiry will work with EPUT.

This was fully supported by the Trust and our legal advisors. The Inquiry confirmed that they would complete an initial draft and send over the EPUT for review, which would include how EPUT would send evidence to the Inquiry, standardised timelines for responding to requests and regularity of meetings. Unfortunately, the first draft was not received until July 2022 and despite drafts having been returned quickly by the Trust, this document has only recently been received by the Trust.

Engagement With Staff

The open letter also implicates staff (past and present), as well as the Trust, of not coming forward when asked.

The Trust has worked closely with the Inquiry to facilitate letters to both current and former staff, in the format and approach requested by the Inquiry secretariat. This included open statements from me, as CEO, offering support for the Inquiry and providing written confirmation that no consequences will occur for any staff who gave evidence to the Inquiry. EPUT issued a letter provided by the Inquiry to all current staff on 13 September 2022. A request to issue the letter to all historic staff was made by the Inquiry. EPUT sent circa 8150 letters via email. Circa 6500 former staff did not have an email address registered with the Trust and the Inquiry took the decision not issue letters by post to these remaining staff.

I know that the Trust offered further support on 11 January 2023 to the Inquiry who acknowledge the considerable support and reassurance the Trust had already given and prior to this date organised drop in sessions for the Inquiry team to meet with staff working on the wards.

In addition, the Trust has, from the commencement of the Inquiry, provided wellbeing support for all staff and patients that may have been affected by the announcement of the Independent Inquiry.

I would urge you to work with us to rearrange further visits to speak directly to our staff – offering reassurance and encouragement which we can also support.

I have not been made aware of any staff that have refused to attend an evidence session following a specific invitation. Nor am I aware that there has been any escalation to my team of problems engaging staff. If staff are specifically requested to give evidence to the Inquiry I have made clear to the Inquiry team, and to staff, that those who are employed by EPUT will be expected to give evidence.

Overcoming the Challenges

I have been asked, and given some thought to, what can be done to ensure the Independent Inquiry can meet its Terms of Reference. I think there are 5 areas:

1) An increase in capacity and expertise in the Inquiry team. The resources you have available to you look less than comparable inquiries. I have made clear when I am asked that I support an increase in resources.
2) There need to be appropriate information sharing protocols, and associated governance in place.
3) There needs to be an improved level of trust between the Inquiry team and the Trust in order that we can work together to find solutions to the challenges you set out. This will enable oversight from senior clinical leads who will be able to talk directly with staff and encourage their participation. Through this joint working we will be able to

articulate clear messages that the Trust is working closely with the Inquiry through joint staff engagement opportunities and briefing sessions.

4) There needs to be a more direct invitation to staff to attend and we need to agree escalation protocols and an agreement that the Trust can play a more active role in encouraging and supporting staff to come forward. I am very confident we can increase engagement with this approach.
5) Reinstating the engagement sessions planned by the Inquiry team with staff groups.

In addition I have been in touch with Anthony McKeever (Mac), Chief Executive of Mid and South Essex ICB. Mac is also happy to link more closely with the EMHII team to also provide support in facilitating the work of the Independent inquiry.

I remain clear that we fully support the Inquiry and will continue to do everything we can to make it a success. I am, of course, open to constructive criticism about the role EPUT can play in supporting it.

I think it is imperative that we meet at the earliest opportunity to share perspectives and to try and move forward positively.

Summary

- I believe I have clearly evidenced that the Trust put in place strong arrangements to serve the Inquiry.

- Any limitations to the searches, and provision of information relating to the Inquiry, are a consequence of the nature of the records. Staffing and resource has not been an issue in limiting the thoroughness of searches requested by the Inquiry.

- I have not been advised that staff (past or present) have refused to give evidence to the Inquiry. The Trust has actively encouraged staff to do so.

- I fully support the Inquiry's objectives and will do everything in my power to make it a success. I have made some suggestions where we can strengthen things.

I look forward to working with you in the future so the families affected can get the answers they need and we can continue to improve Mental Health services.

Yours sincerely

Paul Scott
Chief Executive

Appendix 1

Essex Partnership University NHS Foundation Trust Board Principles

The Trust Board has adopted a set of principles to underpin the approach the Trust will take during the Independent Inquiry into the deaths of NHS mental health patients. These principles will inform how the Trust and its employees should respond to the Inquiry during the period of its work.

1. The Trust Board will be completely honest, open and transparent in its dealings with the Inquiry

2. The Trust Board expects all employees of the Trust to be completely honest, open and transparent in their dealings with the Inquiry

3. The Trust will do its upmost to provide information to the Inquiry as quickly and accurately as possible

4. The Trust Board will expect employees to be entirely cooperative if they are asked to assist in providing information to the inquiry by the Internal Independent Inquiry Project Team

5. If current employees are requested to attend an evidence session by the Inquiry, the Trust Board will expect them to attend and assist with its enquiries

6. The Trust Board will expect all current employees giving evidence to the Inquiry to provide factually accurate answers

7. The Trust will ensure the welfare of all staff throughout the Inquiry

8. The Trust Board see the Inquiry as a positive learning experience, and will ensure that throughout the process all opportunities to embed learning and improve services are taken

Suicide in Essex Partnership University NHS Foundation Trust

- For the period January 2000 to December 2018 there were **93,848** suicide and probable (open verdict) suicides in England and Wales (based on date of death).

- **24,807 (26%)** of these suicides and probable suicides were in contact with mental health services within one year prior to death.

- In the same period, there were **3,281** suicides and probable suicides within the area in which your trust falls.

- **909 (28%)** of these suicides and probable suicides, were in contact with the mental health services of **Essex Partnership University NHS Foundation Trust** within one year prior to death. This number covers a time period when there were previous configurations of the trust.[†]

[†] Essex Partnership University NHS Foundation Trust is the current trust. Previous configurations include North Essex Partnership (2001-2017), South Essex Partnership (2000-2010), SEPT (2010-2017, including Bedfordshire & Luton services in 2010-2015), and Essex Partnership (2017-2018).

Table 1: Key characteristics of patients who died by suicide

Year	2000-2018	
	Essex Partnership University NHS Foundation Trust†	**England & Wales**
Data available on all of those in contact with services in **Essex Partnership University NHS Foundation Trust†** within one year prior to death ***Percentages given are valid percentages***	**909**	**23,898**
Age Median (Min-Max)	45 (15-98)	45 (10-100)
Sex Male	585 (64%)	15,849 (66%)
Female	324 (36%)	8,049 (34%)
Ethnic origin (where known)		
White	842 (96%)	21,496 (92%)
Black & minority ethnic group**	39 (4%)	1,768 (8%)
Employment status (where known)		
In paid employment	157 (18%)	4,557 (20%)
Unemployed**	424 (50%)	9,785 (43%)
Housewife/husband	45 (5%)	968 (4%)
Full-time student	9 (1%)	407 (2%)
Long-term sick*	97 (11%)	3,306 (15%)
Retired	108 (13%)	3,407 (15%)
Other	11 (1%)	257 (1%)
In-patient at time of death	77 (9%)	2,269 (10%)
Died within 3 months of discharge from in-patient care	167 (20%)	3,957 (18%)
Non-adherent with drug treatment in the month before death	91 (11%)	2,971 (14%)
Missed last contact with services	210 (26%)	5,260 (25%)
Primary diagnosis		
Schizophrenia & other delusional disorders*	113 (13%)	4,076 (17%)
Affective disorders*	427 (49%)	10,447 (44%)
Alcohol dependence/misuse	71 (8%)	1,803 (8%)
Drug dependence/misuse**	53 (6%)	964 (4%)
Personality disorder	68 (8%)	2,205 (9%)
Method of suicide		
Hanging/strangulation*	352 (39%)	10,204 (43%)
Self-poisoning**	286 (32%)	5,837 (25%)
Gas inhalation	26 (3%)	664 (3%)
Jumping/multiple injuries	131 (14%)	3,556 (15%)
Drowning*	33 (4%)	1,319 (6%)
Other	78 (9%)	2,231 (9%)
History of self-harm	559 (64%)	15,303 (66%)
History of violence*	203 (25%)	4,738 (21%)

History of alcohol misuse	396 (46%)	10,281 (45%)
History of drug misuse**	343 (40%)	7,494 (33%)
Last contact with services <1 week before death**	384 (43%)	11,525 (49%)

*$p<0.05$ **$p<0.01$

†includes previous configurations

Summary

- There were **12** significant differences between your Trust and England and Wales overall, for the time period specified (denoted by * or **). Compared to the national sample, **Essex Partnership University NHS Foundation Trust** as a proportion of all patient suicide deaths had significantly:

    - Fewer patient suicide deaths who were from a Black and minority ethnic group.
    - Fewer patient suicide deaths who were on long-term sick leave.
    - Fewer patient suicide deaths with a diagnosis of schizophrenia.
    - Fewer patient suicide deaths by hanging.
    - Fewer patient suicide deaths by drowning.
    - Fewer patient suicide deaths with recent (<1 week) contact with services.

    - More patient suicide deaths who were unemployed.
    - More patient suicide deaths with a diagnosis of affective disorder.
    - More patient suicide deaths with a diagnosis of drug dependence/misuse.
    - More patient suicide deaths by self-poisoning.
    - More patient suicide deaths with a history of violence.
    - More patient suicide deaths with a history of drug misuse.

- **Note:** Differences between patients who died by suicide under Essex Partnership University NHS Foundation Trust care with those in England and Wales as a whole, may reflect differences in practice configuration and patient population, rather than safety. Some differences, though significant, are small, reflecting the large sample.

Table 2: Number of patient suicides and in-patient suicides per year in Essex Partnership University NHS Foundation Trust† (2000-2018)

	All patients	In-patients	% of patient suicides who were in-patients
Year	N	N	
2000	41	4	10%
2001	37	7	19%
2002	36	3	8%
2003	50	6	12%
2004	42	7	17%
2005	44	8	18%
2006	39	6	15%
2007	52	<3	-
2008	42	5	12%
2009	45	4	9%
2010	57	3	5%
2011	44	<3	-
2012	75	3	4%
2013	51	<3	-
2014	52	5	10%
2015	51	6	12%
2016	38	<3	-
2017	60	2	5%
2018	53	3	6%
Total	**909**	**77**	**9%**

†includes previous configurations

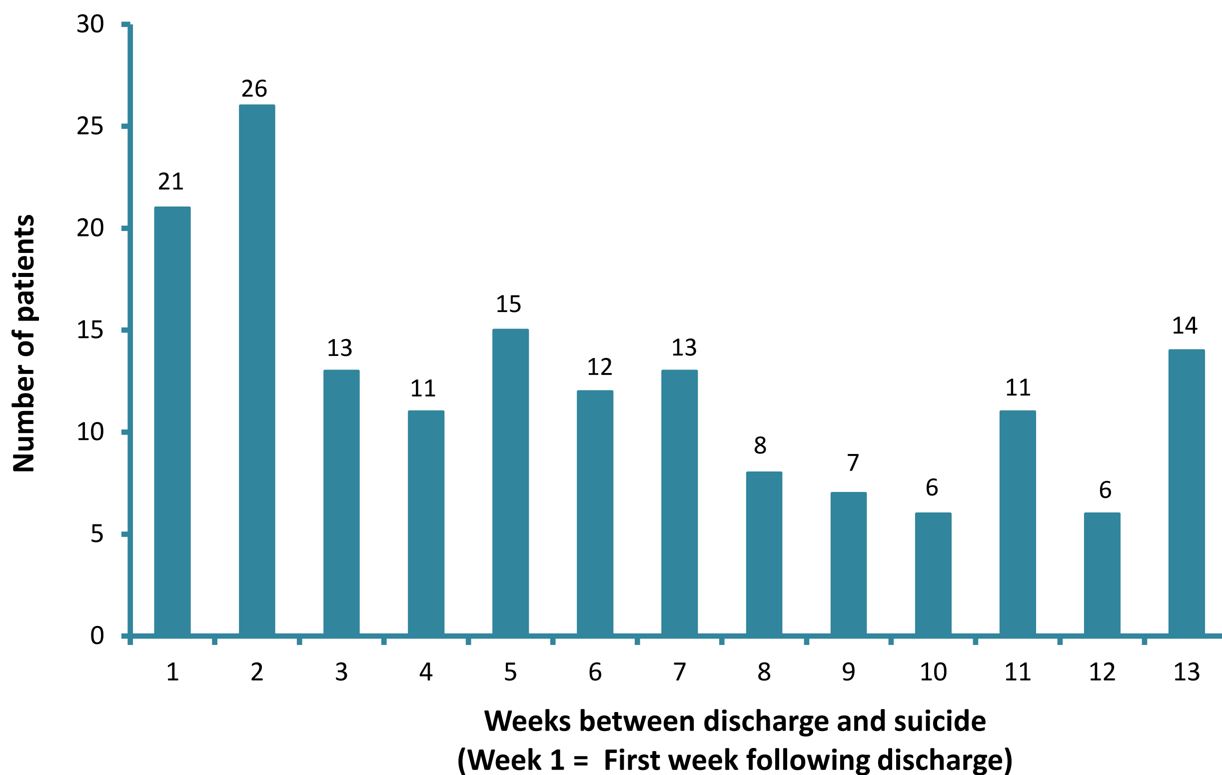
Table 3: Leave status of in-patients who died by suicide (2000-2018)

	Essex Partnership University NHS Foundation Trust†		England & Wales	
Leave status	**N**	**%**	**N**	**%**
Died on the ward	19	25%	690	30%
Off ward with staff agreement	35	45%	1,028	45%
Off ward without staff agreement*	17	22%	470	21%
Unknown	6	8%	81	4%
Total	**77**	**9%**	**2,269**	**10%**

†includes previous configurations

*includes those who off the ward with staff agreement but failed to return

Figure 1: Essex Partnership University NHS Foundation Trust: suicide within three months of discharge from in-patient care – number of suicides per week after discharge



Note: There were 4 patients who died within 3 months of discharge but the number of weeks since discharge was unknown.