Essex Partnership University
NHS Foundation Trust

Chief Executive Office
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Essex
SS11 7XX

[redacted]

Private and Confidential
Ms Sonia Hayes
Area Coroner
Coroner's Office
Seax House
Victoria Road South
Chelmsford
CM1 1QH

Dear Madam,

I am writing to set out the Trust's formal response to the report made under paragraph 7, Schedule 5, of the Coroners and Justice Act 2009 and regulations 28 and 29 of the Coroners (Investigations) Regulations 2013, dated 27th January 2023, which was issued following the inquest into the death of Jayden Booroff. The Trust has provided a response in acknowledgement of your concerns.

I would like to begin by extending my deepest condolences to the family of Jayden. This has been an extremely difficult time for them and I hope that my response provides Jayden's family, and you, with assurance that the Trust takes their loss seriously and has taken action to address the issue of concern raised in your report.

1. **Essex Partnership NHS Foundation Trust risk assessments missed key risk information that led to a reduction in observations levels on the ward.**

Following the incident on the evening of Friday 23rd October 2020, a number of immediate actions were taken related to sharing information about patient risk and the communication of this between professionals:

- The Trust handover process was reviewed. Following this review, the electronic handover sheet was revised. The auditing of handovers was increased to weekly for assurance via Matrons Assurance Tendable audits.
- The Trust engagement and supportive observation processes were reviewed. Following this review, the document in which observations are recorded on was revised to support recording of actual time for each observation. Policy revisions related to roles for decreasing observations and auditing of observations was also added to the Matrons Assurance Tendable audits.
- The Trust appointed a medical quality lead who has taken the lead on excellence in medical record keeping.

An observation and engagement task and finish group was established to undertake a full review of processes and implemented a number of improvements including:

- An ‘Engagement and Observation Plan’ was introduced to specifically record the commencement and ongoing review of a prescribed level of observation. The plan also identifies whether there has been any increase or decrease in observations and eventual discontinuation, based on the risk the patient identifies with.
- Development of new training videos for all staff, including temporary staff members.

Further learning was identified following the full investigation of the incident and the following key actions identified:

- The Trust has implemented a new electronic clinical dashboard, which provides an overview of documentation for ward staff. This is used at handover, and allows staff to view the three most recent clinical entries for each patient, including up to date risk assessments and observation levels. Record keeping audits also take place to support assurance and monitoring processes.
- The expectation is that the quality of risk assessments completed by our staff is reviewed during staff monthly 1:1 sessions with line managers to ensure that all staff are maintaining good record keeping. Five Deputy Directors of Quality & Safety are in post supporting and working with operational managers collaboratively to ensure the embedding of this process.
- In relation to the risk information which led to a reduction in the engagement and supportive observation levels; the Trustwide Engagement and Supportive Observation Procedure was further reviewed in January 2022 and outlines decisions about the level of observation should be made by the multi-disciplinary team (MDT). The procedure also references the requirement of considering a patient’s risk assessment in the decision discussion of observation levels. In particular, that a risk assessment is completed through interview with the patient and carers, careful study of the patient history, use of ratified risk assessment tools, and include assessments of other professionals. A patient’s care plan will contain the rationale for the observation level agreed, details of their risk assessment and how this is managed.
- The Trust’s Clinical Guideline on the Prevention of Suicide is currently under review and will incorporate changes to national guidance. The risk assessment component of the Clinical Guideline is written in accordance with current national guidance whereby risk formulation is individualised and informative to risk management and not a checklist to predict suicidal behaviour.
- At present, risk assessment documentation within Paris and Mobius are “trending” which means they capture information from the previously typed risk assessment and pull this automatically into a new risk assessment form. This will ensure that risk history is included within one place, whilst new identified risk can be included to ensure the comprehensive nature of the assessment. The information can be considered when making clinical decisions with the patient and their family, and can be incorporated into their risk management plan.

The following improvements have been made in the recent months:

- Behavioural standards have been discussed at handover meetings, highlighting importance of concentrating during Observation and Engagement.
- The Trust has re-circulated the observation training video to all staff (including making this available to all temporary workers).

In addition, changes have been undertaken with wards to strengthen Nursing handovers and Safety Huddles. Nursing handovers are supported by safety huddles during the shift to maintain a responsive cohesive response to changing needs of patients and the environment. Nursing handovers ensure the transfer of high quality information and to ensure the duty of care is maintained. Effective handover of patient clinical information is a key component of continuity of quality of care and promoting patient safety.

A Safety Huddle is a short, stand-up meeting – 10 minutes or less to provide teams a way to actively manage quality and safety, including reviewing risks and sharing important information. Huddles can be impromptu and requested by any staff member when there is a safety and risk concern. They provide a quick process to share important information quickly and effectively with the team. Huddles allow the team to review performance and look ahead to flag concerns proactively.

Safety Huddles are to be used as a quick and effective way to share issues and concerns about patients and the ward environment. They support proactive responsiveness to changing needs and emerging risks supporting patient safety and management of escalating situations. Any staff can request a Safety Huddle, but the nurse leading the shift is responsible for chairing a safety huddle during the shift or delegating to an appropriate member of staff. Bi-weekly Senior huddles take place whereby acuity and observation levels are discussed by the senior team.

The Trust continues with observation assurance monitoring and has strengthened some of these processes. Key assurance monitoring includes:

<u>Tendable audit:</u>

- Ward Manager and Matrons Assurance Tendable reports are completed on alternative weeks which provides the assurance on ‘relevant risks’ being recorded within the records.
- Observation and engagement audit tools are in place which looks at whether:
    - the patients observation records were recorded
    - observations were undertaken in line with their current observation and,
    - whether rational was identified for the increase or decrease to any observation level changes.

The findings are reviewed and discussed weekly within the Inpatient Clinical Support Group.

<u>Clinical Audits:</u>

Adult Inpatient Wards Record Keeping Audit continues to be part of the Trust Clinical Audit Programme. Clinical audit is a proven method of quality improvement and an important mechanism for providing assurance in relation to the provision of safe and effective patient care. It gives staff a systematic way of looking at their practice and making improvements.

The audit focuses on the records within the Electronic Record System to confirm if all service users within each service has an up to date risk assessment which includes a risk management plan, and ensuring that the MDT have had input into the risk assessment, whether observation levels have been care planned and confirmation that the crisis plan been discussed / agreed with the service user and/or family.

2. **There is a lack of understanding at Essex Partnership NHS Foundation Trust level about the difference between:**
    a. a patient who has been granted section 17 leave under the Mental Health Act who does not return from a period of authorised leave, and
    b. a patient who being subject to detention under the Mental Health Act, who has escaped from the confines of the ward and who has not been granted section 17 leave by the Responsible Clinician

and therefore, there is a concern as to how this information is then communicated to emergency services searching for the patient of the risks of self-harm.

A detained patient is someone who has been placed under a section of the Mental Health Act. An informal patient is one who has agreed to come into hospital for treatment voluntarily and has capacity to make this decision. Informal patients are able to leave the ward as they please as they are voluntary patients but they would need to confirm this with staff on duty who can make sure they know where the patients are but also to assess that they are fit to leave and not a risk to themselves or others. For detained patients under the Mental Health Act they will need authorisation to leave the hospital grounds which is given under section 17 of the Mental Health Act. The Trust's Mental Health Act procedure outlines the differences in leave for patients detained under the Mental Health Act. Access to the Dashboard during handover also reinforces the communication of the patient's status under the Mental Health Act and their leave arrangements.

In light of communication with emergency services, in collaboration with the Trust's Lessons Team, a one-page aide-mémoire was created to support staff to escalate concerns to the police for incidents where a patient does not return from leave or they have absconded from the ward. This guidance provided information regarding the impact factors that should be verbalised to the police when reporting a person missing. This would then enable the police to make an informed decision in relation to their response. This document uses the SBARD communication tool (Situation, Background, Assessment, Recommendation, Decision). This document was shared with operational managers for cascading to front line staff and calls will be audited between EPUT and Essex Police to ascertain the effectiveness of the tool. It includes prompts for staff to disclose details of the patient's Mental Health Act status.

3. **Miscommunication between:**

    a. Essex Partnership NHS Foundation Trust to emergency services
    b. Essex Police to Essex Partnership NHS Foundation Trust
    c. Essex Police to other emergency services

In seeking further information, how a risk managed within the confines of a secure mental health ward may change for an escaped patient and whether there is real and immediate risk of serious or fatal harm to self or others, rather than assumptions that language is being used in the same way by different services.

The SBARD document detailed above was presented at the Essex Missing Person Forum and received positive feedback from group members including Essex Police and Social Care. It was agreed that this document should be shared, in order that all partner agencies

throughout Essex could use the same product. This would ensure consistency in approach to reporting missing incidents and provide the potential for inter-agency training.

In December 2022 and January 2023, visits to wards at Chelmsford and Basildon sites confirmed that the guidance posters were on the wall in a prominent position in the nurses' offices and there was an awareness of the purpose of the poster.

In addition, an agreement has been established with Essex Police whereby details of incidents when a patient has been reported as missing are shared with them so the call can be listened to and further learning can be established and shared where necessary.

4. **Lack of an Essex Partnership NHS Foundation Trust senior single point of contact for communications with emergency services who would provide any further information or receive updates and how this could be managed across change of shifts.**

Since the incident, the Trust has appointed a single point of contact where emergency services can request to speak the appropriate senior manager managing the incident. The Trust, Essex Police, British Transport Police and EEAST Ambulance Leads are continuing to build good relationships and communication as described below:

- The Trust have an Essex wide single point of access with a priority 'emergency services line' to the Contact Centre where emergency services can request to be put through to senior management of Inpatient Units & Community Services, and On-Call Managers out of hours (after 5pm and weekends). This emergency line goes to the top of the queue, so answered as a priority and put through to the appropriate manager.
- The Trust have developed good relationships with the police, who are now able to join the Trust twice daily SITREPS on Microsoft Teams with service managers and Matrons to support escalation and communication. This commenced at the beginning of February 2023.
- There are police liaison officers linked to Inpatient Units across the Trust who are active in managing any concerns, working closely with the Matrons.
- The Trust also have a 24/7 Crisis Response Service if emergency services need a physical response/support in the community. There is a priority emergency line to this service.
- Senior police officers and Ambulance Leads who have mental health in their portfolio also have the mobile numbers of the Trust's Executive Nurse, Chief Operating Officer and Director of Urgent Care & Inpatient Services as an escalation route.
- The Trust co-chairs the Essex Crisis Concordat with Essex Police. British Transport Police and EEAST Ambulance Leads also attend. The next meeting is on 4th April 2023, where learning from this Patient Safety Incident and Prevention of Future Deaths report will be shared and communication pathways will be reinforced.

I hope that I have provided you with robust assurance that the Trust has taken steps to address the issues of concern in your report, that we are continuing to take action to strengthen the care provided to our patients, and that patient safety is the Trust's top priority.

Yours sincerely,

[redacted]
Chief Executive
Essex Partnership University NHS Foundation Trust