Essex Partnership University
NHS Foundation Trust

25th April 2023

Private and Confidential
Ms Sonia Hayes
Area Coroner
Coroner's Office
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Chelmsford
CM1 1QH

Chief Executive Office
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Essex
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Tel: 0300 123 0808

[redacted]

Dear Ms Hayes,

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 February 2023, which was issued following the inquest into the death of Sharon Langley. The Trust has provided a response in acknowledgement of your concerns.

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

1. **Essex Partnership NHS Foundation Trust staff immediate emergency response was not followed:**
    a. **pinpoint alarms were not activated immediately on finding Sharon Langley unresponsive**
    b. **there was a delay calling the ambulance and basic key information about the type of the emergency was not relayed:**
        i. **by qualified nurses who made the 999 calls, or**
        ii. **to paramedics on attendance**
    c. **there was a delay informing the site co-ordinator of the emergency even though she was based on the ward and there was a lack of co-ordination of the emergency resulting in the ambulance being called a second time by the site co-ordinator**
    d. **staff trained in basic life support did not assist the two nurses who were attempting to resuscitate Sharon Langley**

- EPUT's Head of Deteriorating Patient Pathways and Resuscitation Training Officer is working closely with mental health wards to facilitate drop-in 'refresher' life support training for clinical and administrative staff dealing with emergency situations. During

the training, the importance of calling for help as soon as possible (i.e. use of pinpoint alarm) is highlighted and discussed in detail (1a, 1b, 1c, 1d).

- The issue of calling for help as soon as possible is also shared during the weekly 'virtual' drop-in sessions which focus on the deteriorating patient. Head of Deteriorating Patient Pathways and Resuscitation Training Officer will continue to work with staff at the Derwent Centre to conduct a medical emergency simulation with the team and the importance of calling for help at the earliest possible opportunity is relayed during the post simulation feedback. In addition, the Trust's training department have shared details of the learning from this incident and inquest for incorporation and sharing within the current training programme (1b, 1c).

- In September 2022, EPUT's Lessons Team shared a Safety Learning Alert which identified examples of learning from good practice (e.g., requesting help in a timely manner from both internal and external colleagues), whilst identifying further learning opportunities. The examples highlighted within the document, were taken from reviews of medical emergencies which occurred within the Trust. I have attached a copy of the Safety Learning Alert (1b, 1c).

- The Head of Deteriorating Patient Pathways and Resuscitation Training Officer, operational colleagues and the Lessons Team are formulating a communication tool for use when contacting the East of England Ambulance Service. EPUT Subject Matter Experts have liaised with external partner colleagues to devise the tool and the specific information which our colleagues will require in emergency scenarios. The questions the Ambulance control room will ask when reporting an emergency have been used as the basis for the communication tool poster. It will include essential information relating to the patients presenting medical condition, as well as site information including address and postcode. This aide memoir poster will be positioned adjacent to the Nurses Station and a laminated copy placed inside the grab bag. This is due to be completed and launched across all wards in May 2023 (1b).

- The importance of informing the Site Coordinator and Doctor, at the time of the medical emergency, will be shared and highlighted by our colleagues who currently deliver the basic life support and grab bag training. In addition, any learning (examples of good practice or areas for improvement) which derives from a medical emergency, can be shared as part of the training (1c).

- A business case, for the creation of an in-house faculty, to deliver the gold standard Resuscitation Council UK 'Immediate Life Support' (RCUK ILS) training to EPUT staff has recently been presented to the Executive Team for their approval. The business case will be reviewed again in June 2023 in order to explore the faculty development as part of the system wide consideration. The RCUK ILS training focuses on leadership and task allocation during a medical emergency (1b, 1c, 1d).

- The Head of Deteriorating Patient Pathways and Resuscitation Training Officer is currently working closely with Carradale Futures, to develop a Standard Operating Procedure (SOP), for use with the deteriorating patent and this will include an A to E

approach ‘aide memoir’ document to assist the team during their physical health assessment. The SOP will link in with the National Early Warning Score 2 system and Situation, Background, Assessment, Recommendation, Decision (SBARD) tool and will aid the recognition and handover of the deteriorating patient (1b).

- In addition, the Head of Deteriorating Patient Pathways and Resuscitation Training Officer is working closely with the Head of Shared Learning to discuss and finalise content for a live Learning Matters: Your Monthly Insight session, to be held in May 2023, which will focus on the identification and management of the deteriorating patient (1a, 1b, 1c, 1d).

- A Task and Finish Group will be arranged by the Trust’s Head of Deteriorating Patient Pathways and Resuscitation Training Officer to explore the use of alternative alert and communication systems related to patient incidents. This will require the support and expertise of external personnel and the Task and Finish Group will assist with the requirements to changes which may be considered. The Group initially met for scoping purposes and plans to meet again on 5th May 2023 to progress discussions and plans (1a, 1c).

2. **There was a difference in the safety measures fitted to the bathroom door on the adjoining Stort Ward that had a self-closure mechanism at the time of Sharon’s death. This mechanism has now been fitted to Chelmer Ward. There is a concern that safety information is not shared across the Trust and known risks are not mitigated appropriately.**

- Safety Alerts related to risk items, such doors, are distributed to all wards and clinical staff via the Datix system. Ward staff would be provided with the details of the risk, and actions they are required to take to reduce the risk. This may include for work to be completed by the Estates Team, which would be communicated with Estates and evidence of completion recorded within Datix. New risks are discussed at the Ligature Risk Reduction Group where the alert is discussed and recommendations are formed for implementations. Action are monitored via the action log and re-discussed for assurance within each of the meetings.

- In addition, The Trust’s Lessons Team have worked with stakeholders to develop a process for communication when there are events where new and significant learning has been identified. The Safety and Learning Command Call scheduled to bring leaders and subject matter experts across the organisation together to discuss the event which has occurred to ensure this is widely communicated across the leadership team. Actions are developed and monitored for completion by the Lessons Team and a communication strategy of sharing the key information up, down and across the Trust is devised.

3. **The Trust was on notice of issues on Chelmer ward with doors to high-risk areas not closing that included the Staff Room and Patient Storeroom.**
    a. **At the time of Sharon’s death, the mitigation on the ward was for staff to push doors to see if they were locked, this was action even though**

evidence was heard that these doors had keylocks and staff had keys that could have been used.

b. **The Patient Storeroom contains items removed from patients as they pose a significant self-harm risk and/or suicide.**
c. **Staff Room that contains items that pose a risk to patients**

Self-closure mechanisms have not been fitted to these doors in a high-risk environment of a secure psychiatric ward even though the risk is known. Evidence was heard from patient safety that it is sufficient to have maintenance manually adjust doors if there are closure issues.

- Since the inquest hearing the death of Sharon, the bathroom door on Chelmer and Stort Wards have been changed to a key lock and the ACT has been disabled from use on these doors; which means the doors are now only accessible via key. The patient store and staff room have locks fitted to them which are accessible via a key which staff would be in possession of. This is to reduce the risk of patients being able to access such rooms which contain high risk items within.

- Clinical teams and the Estates team work closely together to ensure mitigations are in place to prevent harm to a patient, by meeting weekly to address. Any re-occurring issue will be picked up by the help desk/estates engineer and at the weekly huddle any issues. The Estates Team will facilitate installation and removal of locks where required when instructed to consider, and where it is safe to do so.

4. **Chelmer Ward staff did not always report door closure issues either on the ward to the Nurse in Charge or to maintenance. Following the death of Sharon Langley there has been no training on how to report door closure issues reported.**

- The introduction of daily safety huddles since Sharon was an inpatient with EPUT supports effective communication across the clinical team. This would include any concerns they may have with door closures and other environmental issues. Actions are taken from the meeting, which would include the reporting of the concern, and a plan to mitigate against this until it has been resolved. Where the concern is of a clinical nature, the clinicians would be responsible for taking action; and where they are related to Estates issues, the Estates Team member at the meeting would action them. Huddles involving Estates staff take place weekly.

- The process of how to raise issues with Estates is set out within the Trust intranet which is available to staff. Although these is no formal recognised training of how to report an issue with a door closure, this is one of many issues that may be raised with Estates. The key point is that staff are aware of the process by which to escalate matters appropriately. If staff require support to utilise the portal, requests are made via the Estates Helpdesk which are responded to by Estates staff. The system in use at present is 3i. 3i is an estates management system which captures all maintenance issues and requests, which enables the Estates Team to prioritise the tasks. The system is audited for completeness fortnightly by the Trust Chief Engineer.

5. **Evidence was heard that the bath plug was required to be kept in the ward office when not in use as the bathroom was a high-risk area. There was no evidence that staff had to obtain this from the office on the day Sharon Langley died. There still appears to be confusion around the requirement.**

- Following the evidence provided at Sharon's inquest, processes for the management of the bath plug on Chelmer Ward have been reviewed. Bath plugs are not left within the bathroom and a new signing in and out sheet has been implemented across the Derwent Centre. The plug will be signed out on the form by the staff member who is assisting the patient in the bath and signed back into the locked facility following completion of the bath. This includes the time the plug was removed and put back and which patient utilised the bath. The form is also signed by the assisting staff member to provide assurance that the bathroom door has been locked following completion of the bath.

- The bath plug is in a locked cupboard which is not accessible to patients. A signing in and out sheet has been implemented; with the expectation that this is locked away with the plug and staff are to record the use of the plug on the new form. The document was discussed at the Inpatient Clinical Support Group on 5th April 2023 and shared with Trust-wide inpatient Service Managers for use.

- General Workplace Risk Assessments for each ward will be used to contain details of the risk and mitigations for the use of baths and bath plugs. In addition, on 10th May 2023 the Ligature Risk Reduction Group will discuss a consideration for amendments to be made to the ligature inspection tool related to bath plugs.

6. **There is concern about the reliability of the Trust investigation and how the Trust learns lessons. The investigation report did not:**
    a. **scrutinise the movements of staff even though the door logs were available or raise any issues for further investigation**
    b. **raise any issues around the bath plug or where it should be kept**
    c. **investigate concerns raised around the Trust staff emergency response or failure to provide basic information on the incident to paramedics**

- The Lead Investigator and author of the Root Cause Analysis report reviewed the door access control logs as part of the investigation process. The Root Cause Analysis report was completed under the Serious Incidents Framework (SIF, 2015) whereby the expectation at the time was for the report to be completed within 60 days of the date of commissioning. The Lead Investigator has stated that the logs were received after the chronology had been completed and were not analysed in depth due to the timeline above.

- With regards to the bath plug, the Lead Investigator's understanding was that this was a supervised bathroom and therefore the type of plug and any related risk would be mitigated by staff being present at all times, however he does accept that this could have been explored in more detail within the report.

- In relation to concerns raised around the Trust staff emergency response, East of England Ambulance Service raised the potential learning opportunities with EPUT's investigation team and these were addressed in the Lessons Learned section of the investigation report.

- The weaknesses of the Serious Incident Framework have been nationally recognised, which has led to the implementation of the Patient Safety Incident Response Framework (PSIRF, 2022). EPUT were an early adopter of PSIRF having formally implemented on 1st May 2021, and have helped shape the national implementation expectations. With this in mind, under the Trust's current Patient Safety Incident Response Plan (PSIRP), an incident of this nature would have been investigated using a revised and recognised methodology and the date in which the investigation would have been set would allow for a longer period of time to scrutinise the logs against other information to support with a chronology of events, triangulation of events and identification of learning.

7. The Trust investigation author changed the conclusion of his report during the inquest when he received statements provided by staff that were not requested and contained timing information that in evidence staff stated they did not know.

- During the inquest, the Lead Investigator was provided with additional information in the form of staff statements. In response, HM Coroner requested a statement as to whether the review of the ACT logs alter the conclusion of the Root Cause Analysis report. In his statement dated 12th February 2023, the Lead Investigator confirmed following review of the ACT logs, the material findings of the investigation have not changed.

8. Quality of record keeping was not deemed to be appropriate by senior staff during evidence:

a. Significant examples of cut and paste including out-of-date risk information at all grades of ward staff, and

- A recent Trust-wide inpatient and urgent care pathway audit for record keeping was finalised in April 2023. Questions related to copy and pasting within records was included in the audit and this was broken down into care groups. Care groups identified to have an issue with the copying and pasting in records are in the process of the agreeing next steps. For mental health inpatient areas, they are reviewing assurance processes such as Matron's Assurance audit which will feature some questions regarding copying and pasting.

- In the meantime, local assurance to capture incidents of copying and pasting have been embedded. The Ward Manager and Matron completed spot checks of clinical records, and discuss at the daily huddles involving Ward Managers, Matron and Service Manager will identify incidents of copy and paste within the previous 24 hours of documentation so this can be addressed with individual staff members where required. In addition, clinical documentation is reviewed in individual staff supervision

to ascertain whether copy and paste has been used within records they have written, which will be appropriately addressed as necessary.

- Across the wider organisation, EPUT's Lessons Team produced a short animated video with record keeping tips included, and this was cascaded across the organisation on 25th January 2023. On 1st February, the Lessons Team hosted a live learning event entitled "Learning Matters: Your Monthly Insight". The topic of discussion focussed on record keeping, themes of good practice and also the legalities around medical records.

- On 10th March 2023, EPUT's Lessons Team released a Safety Learning Alert which focussed on copying and pasting within clinical records. The Alert noted that copying and pasting had been evident in records within recent inquests, and provided examples of where this had been completed. Learning themes were included within the alert, and actions were set for managers to ensure the key learning had been disseminated and actions had been taken to address the concerns raised. The final action is due for completion in May 2023. I have attached a copy of the Safety Learning Alert.

b. omissions in multi-disciplinary decision-making and risk of self-harm with no rationale for the level of observations set for the patient and a plan for how risks should be managed

- In relation to completion of engagement and supportive observation records, local procedure is in place whereby the observation is completed by the assigned staff member in full. The Nurse in Charge at the end of the shift will sign the observations chart off. These are checked by the ward manager for assurance they've been completed accurately and in full before being uploaded to the electronic clinical records system. EPUT has piloted the use of electronic observations (e-obs) which is now being rolled out across the Trust. Observation levels are reviewed regularly by the MDT and documented within the care review documentation.

- The Trust is currently undertaking horizon scanning relating to MDT communication (including MDT meetings where individual patient risk is discussed and management plans agreed), which is one of EPUT's nine medium to long term continuous improvement areas. The horizon scan tool is part of the NHS Patient Safety Incident Response Framework toolkit and supports health and social care teams to have a forward look at potential, or current, safety themes and issues. The horizon scanning tool uses the Systems Engineering Initiative for Patient Safety (SEIPS) framework to structure conversations about work as done and emerging patient and staff safety risks. The findings will be reviewed and actions taken as required.

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