Essex Partnership University
NHS Foundation Trust

12 February 2024

Chief Executive Office
The Lodge
Lodge Approach
Wickford
Essex
SS11 7XX

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

[redacted]

[redacted]

Dear Ms Hayes,

Morgan Rose Hart (RIP)

I write 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 19th December 2023 in respect of the above, which was issued following the inquest into the death of Morgan Rose Hart (RIP) .

I would like to begin by extending my deepest condolences to Morgan Rose Hart's family. The Trust sympathises with their very sad loss.

The matters of concern as noted within the Regulation 28 Report have been carefully reviewed and noted. I will now respond in full to these concerns in the hope that this provides both yourself and Morgan Rose Hart's family with comprehensive assurance of changes that have been made at the Trust to address the concerns you have raised.

Concern 1:

The Trust investigation was materially incomplete and there was a lost an opportunity to:

a. Understand concerns of the Family

b. Acknowledge errors and learn lessons from the circumstances of the death. The Director of Operations and Matron informed the Trust Senior Management that the PSII Report had omissions. The Trust evidence was that it was an early adopter of the new NHS investigation process. The lead investigator did not report on material issues as to how Morgan-Rose was observed on the ward and the report was significantly delayed. Evidence was there was a pressure to sign the report off although it remained incomplete and did not contain a note about the limitations.

c. Escalate concerns about staff observations - About 2 weeks after the death the Matron received a report that staff observations had not been appropriately conducted. This prompted a review of CCTV from the afternoon of Morgan-Rose's death. There was insufficient scrutiny of the CCTV that showed that multiple observations entries made on 6 July 2022 after 14:06 hours could not be correct.

d. Understand security issues on a locked mental health ward - It has not been possible to establish the identity of the person that reset the bathroom alert triggered for Morgan-Rose on 6 July 2022 at 15:31. The Trust does not have an accurate records of Trust staff pass allocation. The Trust investigation did not establish that staff borrowed each other's security passes. On the day of Morgan-Rose's death a visitor pass issued that had access to the nursing office. The Trust was unable to provide the identity of this person.

Response:

The Patient Safety Incident Response Framework (PSIRF) is a major step towards improving safety management across the healthcare system in England and will greatly support the NHS to embed the key principles of a patient safety culture. It will ensure the NHS focuses on understanding how incidents happen, rather than apportioning blame on individuals, it allows for more effective learning and improvement, and ultimately making NHS care safer for patients. EPUT was an early adopter Trust for PSIRF implementation and went live in May 2021. However, we recognise that the investigation for this Inquest contained regrettable omissions. Please see below the training that has been put into place to address the omissions found in the investigation for this case.

Having been part of the early adopter organisations, we remain committed to working towards the required improvement to ensure PSIRF is fully implemented safely in the Trust. The changes are reflected in the final PSIRF guidance which was published in August 2022 by the National Safety team.

The Patient Safety Incident investigation report in this matter was completed under the previous process that was implemented in the Trust during the early adopter period.

The Trust has now convened a PSIRF Improvement Oversight Project Board which is chaired by the Executive Nurse and will report into the Safety of Care Committee which is chaired by the Chief Executive Officer.

Improvement activities include:

- Development of the Safety Improvement Plans (SIP) for identified themes form historic learning (action plans under the SI Framework were singular and related to the individual patient, SIPs are identified in the Patient Safety Incident Response Plan (PSIRP) which are system based improvements using data and information from the themes from the individual incidents).

- Steps taken to ensure our processes including reporting templates are refined to ensure there is significant shift in the way we respond to patient safety incidents.

- We have commissioned a series of training, learning and development activities both internal and external to ensure staff are trained in the new PSIRF guidance approach including senior leaders who provide oversight for PSIRF process.

- We have proposed changes to family engagement in the new process. The Family Liaison Officer and Learning Response Lead will meet with the family at an early stage to discuss Terms of reference / draft report and final report before this is shared. The Duty of Candour requirement will be met through engagement with family by operational leads and learning response lead.

- Governance arrangements have been reviewed and currently being adapted which includes identification of early learning through collaborative approach with the care unit leadership, deputy directors of quality and safety subject matter expert and people with lived experience for example our patient safety partners, who are actively involved in the review process.

- The PSIRF Policy is being updated to reflect best practice. The policy includes time scale for completion of a learning response review and timely sign off. The policy also includes process for the management of safety action plan and cascading of learning across the trust.

- It will take time to implement and embed the revised approach, and there will be significant learning as we progress the improvement plan. We are however, committed to fully implementing the revised framework, and really changing the way we work and think to improve patient safety learning and make our care delivery safer.

- Further, following a patient safety incident the following new 'post incident immediate actions protocol' will ensure that security measures in relation to the signing in and out of patient related records are immediately collated:

    - The collation of staff statements of those attending to the patient in respect of the care, practice, interventions, roles and responsibilities during the shift enabling the investigator to triangulate all written data with digital data including CCTV, Oxevision and body worn camera footage.

    - All wards have an allocated security lead/nurse 24/7 on each shift to support the Nurse in Charge and ensure that all ward staff have their own security passes (ACT), at the beginning of a shift.

    - Whilst the Trust has a system for ensuring that all substantive staff have their own ID and security passes (ACT); temporary staff are now also issued their own 'numbered' security pass at the beginning of a shift. These are signed for so there is an accurate record kept by the ward, and returned at the end of a shift. It is the 'nurse in charge' responsibility with support from allocated security lead/nurse to ensure that all staff receive their own pass and sign them out and in.

    - Each unit has its own stock of security passes (ACT cards) to ensure that the ward doesn't run out if any get taken home by accident, to prevent staff from sharing. Unit Administrator leads monitor the stock and order more when needed. The security passes (ACT) are numbered so they can be traced to the staff name that they were given to through the signed ACT record sheet.

    - The requirement to preserve records is being re-enforced by the Trust. The Trust's Records Management Policy is being updated, with the addition of a poster for inpatient services which outlines records/data which need to be retained and the process to follow within the initial 24 hour period. This will be distributed to mental health inpatient services. The updated policy contains further details of records retention the Trust will take after the initial 24 hours post-incident and within non-inpatient services. In addition, the Trust's Adverse Incidents Policy is being updated to include the actions to be taken following an unexpected death wider

than records retention, such as contact with family, preservation of the scene and informing the police of the incident.

Concern 2:

There was a dispute in evidence over whether it was or was not permitted for patients to have belts on Chelmer Ward that has not been resolved.

a. Morgan-Rose was on 1:1 observation due to her high risk of self-harm that including ligaturing and a belt was in her possession

b. The Responsible Clinician and a Ward Manager providing support to staff gave evidence at that time that belts were not permitted

c. The Trust senior management stated that belts were permitted and referenced the policy. The updated ward documentation 'Handover Checklist' approved in October 2023 contains belts on a list of prohibited items. The Trust has stated that this is not correct although this was part of the After-Action Review and is in current use

Response:

The Trust's Global restrictive practice Guideline on the use of Global Restrictive Practices in In-Patient Units and the Restricted and Prohibited Items List – Inpatient Units CG92 – Appendix 1 has been updated and the restricted items reviewed through the Trust's Restrictive Practice Trust Steering Group and Co-Production in December 2022.

Belts continue to not be named on the prohibited items list in adherence to reducing restrictive practice for all, however, if a patient has a risk history of attempted ligature or is a risk to themselves then personal belongings will be reviewed and any identified risk will be reflected in care plan/risk management plan.

EPUT Trust policy states:

'Risk assessments and personalised care related to restricted items access will depend on many factors, some of which may be fixed and others subject to change. The risk assessment and ensuing management of access to security items should take a procedural and individualised approach, where possible in collaboration with the patient, which avoids the implementation of unreasoned blanket bans. For items that may be considered suitable only for restricted use, staff should complete a thorough risk assessment and provide the patient with a transparent rationale that explains the management outcome.

A dynamic and personalised risk assessment considers: 1. Personal risk: individual's historical risk and current mental state 2. Interpersonal risk: direct risk to others- patients and staff 3. Environmental risk: ward dynamics; general service safety (level of security, rehabilitative/acute) 4. A common sense consideration of the item in question'

All clinical areas have been provided with a copy of the above policy and prohibited list including newly revised handover forms that went live January 2024. The list referenced in the new Trust policy is also in the 'new information for patients, relatives and carers welcome pack'; in order to better facilitate family engagement.

A new digital app providing instant and easy access to Standard Operating Procedures has been developed. Implementation is in progress, with the rollout commencing in May 2024.

The EPUT Culture of Learning Lessons Team are developing and circulating a learning briefing to clarify correct process and share learning regarding restricted items and highlight other high risk items not included on the list. The learning brief is to be informed by existing policy.

Concern 3:

Escalation of risk – Morgan-Rose attempted to secure unescorted leave on the morning of her death, her Responsible Clinician had only authorised escorted leave. This was not escalated to the nurse in charge and the Responsible Clinician was not informed.

Response:

EPUT are adopting and implementing an evidence based framework within inpatient services to support engagement, care planning and therapeutic intervention. This is an internationally recognised framework which will support a positive cultural change across all our ward environments around therapeutic engagement, holistic care planning (including leave plans), whilst considering the context of care. This will include re-establishing the 'named nurse' function and responsibilities.

It will be the responsibility of the named nurse to ensure that all their patients have completed a ''My Care, My Leave Plan", which is signed by the patient and Health Care Professional, and reviewed by the multi-disciplinary team and Consultant/Responsible Clinician in ward reviews. These plans are to promote the patient voice, support the overarching electronic care plan and include following headings:

- When will I go on leave
- Where will I go
- My favourite places
- Who will accompany me
- When will I return
- What should I do if I am running late to return to the ward
- How can the ward contact me
- How can I get help when I need it
- Approved by

The plans are kept in the nursing office so the teams can easily reference and are audited by the Matrons.

Communication will be improved within the multi - disciplinary team by reviewing the impact of the multi-disciplinary team safety huddles through a Qi methodology. As well as implementing improvements in the handover process with the introduction of the nurse in charge checklist and task allocation.

As the Court will be aware, Morgan Rose (RIP) was an informal patient. However, going forward the International Fundamentals of Care Framework will compliment Multi – Disciplinary Care planning and communication whilst supporting the Trust 'Clinical Guidelines for Managing Leave with Informal Patients and Patients Detained under the MHA.

Concern 4:

Bathroom alerts – Evidence was heard that an Oxevision alert is triggered if a person is in the bathroom for more than 3 minutes and staff are required to complete an in-person check. Morgan-Rose was left in the bathroom unobserved for approximately 50 minutes. It was not clear from the evidence how the Trust proposes to ensure compliance in respect of this duty.

Response:

Configuration changes to the Oxevision system have been implemented. This will ensure that bathroom alerts continue at 3 minute intervals until an individual has exited the bathroom. This includes the reset functionality of a repeating audible and tile illumination of an alert with timer continuation after each successive reset of the alert in 3-minute intervals.

A clinical review of the SOPs for Oxevision and Oxevision Observations to align terminology and produce updated versions of the SOPs has been implemented. This includes ensuring the continuity of terminology in the SOP and all communications mirroring system based terms and wording.

The change of use of 'mute alert' to 'reset alert'. When an alert is reset, the audible alert is turned off not muted.

All clinical staff are being retrained or trained in the use of Oxevision and observations. In line with the Oxevision SOP and the Therapeutic engagement and supportive observation policy.

DATIX data reflects that staff are using Oxevision in adherence to policy and responding to alerts which has resulted in no harm. The Inpatient Leadership team continue to spot check ward practice and review DATIX data.

Managers of all levels are continuing to carry our spot checks on the safe use of Oxevision. Training logs are also comprehensively maintained.

Concern 5:

Trust oversight of care – the quality of record keeping was acknowledged not to be appropriate by nurses and senior staff during evidence, yet had been signed off:

a) Observations sheets for vulnerable detained mental patients were signed off by nurses in charge as being appropriate despite an absence of any recorded therapeutic engagement
b) Omissions in the recording of food and fluid charts required by the Responsible Clinician for a patient who was losing weight with a diagnosis of Body Dysmorphic Disorder.
c) The Responsible Clinician's evidence was that the absence of appropriate food and fluid charts for other patients was an ongoing issue on Chelmer Ward that had been raised with nursing staff.

Response:

The review of the Therapeutic Engagement and Supportive Observation policy has been completed and circulated to all staff.

We have rolled out ‘e-observations’, across all wards, which is a mobile tablet (IPAD) electronic observation recording system; which records the patient observation with detail of patient presentation and engagement in the moment. There is an audit function within the system to enable ward managers to audit the quality of recording and engagement on a daily basis. There is an Oxehealth E-observations Project Board that has oversight of implementation, delivery and outcomes.

We are currently implementing *The International Fundamentals of Care Framework* which outlines what is involved in the delivery of safe, effective, high-quality fundamental care, and what this care should look like in any healthcare setting and for any care recipient. This programme is being jointly led by the Nursing Directorate and Operations. A Matron lead post has been appointed to support implementation across all inpatient teams.

The Framework emphasises the importance of nurses and other healthcare professionals developing trusting therapeutic relationships with care recipients and their families/carers. It also emphasises the need to integrate people’s different fundamental needs; namely their physical (e.g. nutrition, mobility) and psychosocial needs (e.g. Communication, privacy, dignity), which are mediated through the nurses’ relational actions (e.g., active listening, being empathic, physical health monitoring).

All wards now have Registered General Nurses (RGN) in addition to Registered Mental Health Nurses (RMN) to support physical health care including a focus on nutrition. This is an outcome of the EPUT ‘Time to Care Model’ and has been supported by International Recruitment. The wards also have physical health champions embedded into their teams.

All inpatient nursing staff are completing the Food and Fluid Refresher training delivered by the Professional Development Team.

Concern 6:

Staff entries in patient observations sheets should have given rise to a concern that some staff may have been using Oxevision not just as an adjunct to face-to-face observations, but instead of them. This remains a concern.

Response:

The review of the Therapeutic Engagement and Supportive Observation policy has been circulated and reinforced on all wards. There is much more of an emphasis on the importance of therapeutic engagement during observation.

A further training programme for all clinical staff commenced on 22/01/2024 on Oxevision and E-obs. This will consolidate clinical staff’s knowledge and skills and ensure compliance with Oxevision SOPS and the Therapeutic engagement and supportive observation policy.

Datix data reflects that staff are using Oxevision in adherence to policy and responding to alerts which has resulted in no harm. The Inpatient Leadership team continue to spot check ward practice and review DATIX data, providing role modelling, leadership and oversight.

I hope that I have provided reassurances around the steps that we have taken to address the issues of concern contained within your report. We know there is an acute need to embed and effect change, hence we will monitor the above provisions to ensure these are contributing to our overall aim of keeping patents safe and delivering therapeutic care.

Please do let me know if you require any further information at this stage, including copies of any of the documents referred to above.

We will await your direction before sharing a copy of this reply with the family.

Yours sincerely,

[redacted]

Chief Executive