Essex Partnership University
NHS Foundation Trust

12th May 2025

Private and Confidential
Mr Sean Horstead
HM Area Coroner
Coroner's Court
Seax House
Victoria Road South
Chelmsford
CM1 1QH

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

Tel: 0300 123 0808

Dear Sir,

Mr Darren Neil Turner (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 17th March 2025 in respect of the above, issued to the Trust following the inquest into the sad death of Mr Turner.

I would like to begin by extending my deepest condolences to Mr Turner's family. The Trust sympathises with their 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 Mr Turner's family with comprehensive assurance of changes that have been made at the Trust to address the concerns you have raised.

Concern a) Failures in Care Planning: specifically, a failure to appropriately up-date and document matters relating to Darren's Care Plan consistent with Trust policy. The last up-date to his Care Plan was 12 days prior to discharge.

Response:

We can provide assurance that there is an expectation that care plans are reviewed as a minimum weekly or following any incidents or change. To further support this changes are being made to ensure care plans are discussed at the weekly MDTs.

To support staff in meeting this expectation a further Trust communication will be circulated reminding staff of the importance of regular review of the care plan.

The Ward manager undertakes weekly oversight of all care plans for inpatients through auditing (via the Trust Tendable system) and the quality of care planning is discussed at supervision. The outcome of such audits is shared via the Care Unit Local Quality and Safety Group and is visible via the Trust Tendable Dashboard and through to the Care Unit Accountability Meeting and Trust Quality Committee.

Care plans are developed in partnership with each patient and their named nurse.

Development and implementation of a new operating model includes daily Red2Green MDT morning ward rounds where every patient is discussed and any changes to care plan informed. This supports the weekly MDT review.

A Quality Improvement Project has been undertaken on Gosfield Ward with support from the Trust QI Hub. The aim has been to review care plans to ensure they are individualised, of value to our patients and in a supportive template for continual review. The project has included focus groups with patients to understand what must be included in their care plans. Patient feedback has been recorded, and this has informed the content of the care plan templates being piloted on Gosfield Ward.

'My care, my recovery' workshops have been held to ensure the above plans are working / meeting expectations.

Wards now have a Practice Nurse Educator (PNE) aligned to the ward, to help guide and support ward staff. This includes ongoing skills development including in relation to quality of care plans.

The PNE also undertakes care planning audits. Where auditing finds gaps or improvements needed the PNE will take this forward directly with individual members of staff.

The Trust has also initiated person centered audit (through the Trust Tendable audit system) which includes the review of care plans. Audits are undertaken on a monthly basis.

Positive feedback on the above changes have been received from staff.

The Trust is continuing focus care planning and will be holding a dedicated Care Unit Local Quality and Safety Group to spotlight

Concern b) Failures in Documentation: in a number of acknowledged respects the electronic records were inadequate - and inconsistent with EPUT policy -with evidence of the *'cutting and pasting'* of entries including Darren's initial 72-hour care plan containing details of another patient entirely.

Response:

The Trust has initiated a Record Keeping Safety Improvement Programme (SIP). Part of this includes considering how to address issues of copying and pasting. This SIP program is focusing on improving patient safety in respect of documentation specifically. The SIP is aiming to understand motivations for copying and pasting and putting systems in to address these. The approach will be to support continuous learning and improvement and regular review.

The Trust has initiated a person centered audit (through the Trust Tendable audit system) which reviews care plans. In addition there is the Matron Assurance Audit which includes specifically looking at if there is evidence of copying and pasting. Audits undertaken on a monthly basis and improvement monitored on the wards where required. These audits are supported by PNE's (as detailed above) and as outlined above pick up through supervision. If there is continued non-compliance then HR processes are initiated as appropriate.

Essex Partnership University Trust and Mid and South Essex NHS Foundation Trust (MSEFT) are working together to implement 'NOVA', a new and single Electronic Patient Record (EPR) system across our services, which will pull through risk information which will negate need to repeat information.

In designing and implementing NOVA the Trust will work with Oracle Health. The new, unified EPR system will be a first of type in the NHS and will replace/integrate with current systems across EPUT services in all areas and will be used jointly with MSEFT to cover Basildon, Broomfield and Southend hospitals.

The implementation of a unified Electronic Patient Record (EPR) through the Nova Programme will transform how we collaborate and work as a single health system to deliver quality and safe care to our patients and service users across acute, community and mental health sectors.

Through Nova we will deliver four primary objectives:

1) Reduce administrative burden and improve the working practices of our staff
2) Deliver better and safer patient care and enhance their experiences
3) Improve the health of our patients and communities through our care functions
4) Improve how we work with our partners and the health and care system

Concern c) Failures in Risk Assessments: specifically, failures to appropriately up-date and document matters relating to Darren's risk assessment consistent with Trust policy. Relevant passive and active risk factors were not formally reflected in his documented risk assessments. Evidence from his Responsible Consultant Psychiatrist and the discharging Psychiatrist confirmed that, had they been aware of a disclosure made by Darren to his key worker/nurse prior to discharge, the Section 2 detention *would not* have been rescinded, he *would not* have been discharged on the 17th October and, accordingly, it is likely that he would not have taken his own life the following day.

Response:

A reflective learning supervision session has been held with a member of staff involved in this matter in order to understand the factors in this incident and ensure the staff member understands the importance of communication key information to other clinicians.

The patient safety incident action plan has been shared with the whole team to reflect on identified learning.

The Trust has established family ambassadors on the wards who are a key point of contact for families and are responsible for ensuring information shared by families is recorded and considered by the MDT.

The Trust is rolling out STORM Training (Skills Training on Risk Management). This is an evidence-based training methodology given to frontline team members.

The Trust has initiated a MDT Communication SIP due to the findings from patient safety incident investigations. A working group has been established consisting of senior clinicians and service directors to develop key principles for effective MDT working/communication and documentation. This group will considered the concerns raised by this PFD to ensure this learning is considered as part of the project.

There will be an initial pilot across 4 Trust sites to test and learn the sustainability of the interventions so this can be adopted across all MDT teams and services.

The group will review the national standards and principles for MDT working and evaluate local practice standards to develop an effective tool to guide clinical practice and standardise MDT working across the Trust. This will include:

- Agree baseline principles and guidance to ensure the right information is captured at the right place and at the right time

- Agree key content in MDT communications recording and process to ensure MDT qualitative notes are completed in real time, narratives are captured in timely way and outcome followed through

- Modify existing MDT recording template ~~if any or~~ and adopt an amended version through the test and learn process to enable standardisation across the trust

- Test and learn across 4 sites namely – 2 Inpatient wards and 2 community teams across two geographical areas (West Essex and MSE)

The Trust has developed new digital clinical dashboards available in all wards which displays a range of 'at a glance' quality/performance information. This includes monitoring of risk assessments. All staff have access to this dashboard.

As outlined above Essex Partnership University Trust and Mid and South Essex NHS Foundation Trust (MSEFT) are working together to implement 'NOVA', a new and single Electronic Patient Record (EPR) system across our services, which will pull through risk information which will negate need to repeat information.

Concern d) Failure to allocate a Care Coordinator as required under the Care Programme Approach (CPA) and as mandated by EPUT policy. This failure (resulting from significant human error not detected by an insufficiently robust system and not therefore corrected prior to the death - and in respect of which no DATIX was ever raised) was a feature that contributed to the serious failure in discharge planning in this case.

Response:

On admission, where appropriate, a referral is made for a care coordinator. Community services are using a zoning template which clearly flags new referrals from inpatient services. At the weekly community MH team locality meeting all referrals are discussed for allocation and in-reach planning.

The Operational Manager has implemented a new system where by all ward clerks, medical secretaries and/or ward managers as appropriate, send invites to discharge planning meetings as well as ward reviews via the PARIS (EPR) referral inbox as opposed to one individual team member.

The Operational Manager Band 8A and the Band 7 Clinical Lead as well as the Social Care Senior Practitioner to the Specialist Mental Health Team (SMHT) all have access to the referral inbox mentioned above. This ensures that the referral is not missed and representation from the SMHT at ward reviews is facilitated.

Once the relevant action has been completed by a senior member of the SMHT, the referral is automatically removed from the inbox. The Clinical manager monitors the referral inbox at the end of each week to ensure that all referrals has been actioned accordingly and that

there has been no delay in taking the required action, however if delays has been identified a DATX is raised.

A Flow and Capacity Meeting has been introduced and is held every Monday, at the meeting, referrals, safeguarding investigations and transfers of care are discussed and allocation is made by the senior members of staff within the team, this comprises of the Band 7 Clinical Lead, two Senior Social Workers and a Senior Occupational Therapist. Other relevant staff are included on an hoc basis to ensure that multi-disciplinary discussions takes place accordingly.

Priority is given to allocating service users who are admitted to inpatient wards to avoid any potential delays in discharge planning, and to also ensure that a thorough assessment of the service user's needs, risks and social circumstance take place, and that the service user is aware of the support available to them in the community upon discharge.

The Gables SMHT are currently in the process of recruiting a Community and Inpatient Liaison Nurse lead band 6 Community Psychiatric Nurse (CPN). The post holder is to work directly with inpatient services. All inpatients who are referred to the Gables SMHT will be allocated to this CPN. It is envisaged that the staff member will meet with the patients on the ward, attend ward review and work closely with the inpatient team to ensure a safe discharge, improve communication and provide a more seamless service.

With regards to DATIX not having been raised in relation to this incidence, a memo has been issued to all Clinical Managers in Mid Essex to distribute to all their staff and discuss in their respective Business meetings the requirement for DATIX Incident reporting to be completed for all adverse incidents, adverse events and near misses. Additionally, all supervisors are to ensure that all there supervisees are confident in using the DATIX system and where training need is identified, such refreshers are to be facilitated via the Risk Management Team

Concern e) Failures in Communication including a failure to appropriately liaise with the deceased's Family and, specifically, Darren's mother to establish the suitability and safety of a discharge to her address not least in the context of Darren's disclosure that discharge to his mother's home might *"make him feel worse"* at a point in time that he later acknowledged *"would be overwhelming"* for him.

Response:

Each Unit has been assigned a Family Ambassador whose role is to support and assist with family engagement and information sharing.

Concern f) Failures in Discharge Planning and Execution: specifically, in addition to the features above, a failure to actively reconsider the safety of the discharge on the afternoon of the 17th October in light of the disclosure from Darren's mother that she would not, as had been previously indicated, be able to either collect Darren from the Ward or be at her home when he was discharged. There was no evidence of how, in fact, Darren even left the Unit. It is likely that the chaotic and unsupported nature of Darren's discharge from Gosfield Ward, also in breach of Trust policy, more than minimally contributed to his death some 18 hours after discharge.

Response:

Going forward the appropriate Home Treatment Team will be invited to attend ward review meeting on day of discharge to ensure they have the most up to date information in relation to planned discharges.

Additionally, on discharge, an allocated registered nurse on shift will take responsibility for working with the patient to prepare for safe discharge including home travel plans, ensuring support network plan is in place, contact / follow up advice and crisis contingency plan

The Trust has initiated a Discharge SIP (Safety Improvement Plan). The Urgent Care and Inpatient Care Unit leadership team through the PSIRF process carried out a table top exercise in April 2024 to review inpatient safety incidents where unexpected death had occurred over the last 10 years (2014 – 2024) from an operational, and quality and safety lens.

This 10 year thematic review of in-patient deaths informed the Discharge SIP and contributed to the development of a new in patient operating model in 2024. This along with newly published NHSE guidance for in-patient wards for working age and older people has provided an opportunity for a full review of the culture, systems and process to maximise the patient and staff experience, improve quality and safety and align with community mental health and system partners. The model incorporates four chapters – 'Purposeful Admission', 'Therapeutic Benefit', 'Trauma Informed Care' and 'Proactive, Safe and Effective Discharge' which is supported by a detailed implementation plan, which is currently being mobilised across all adult and older adult wards. Community services and Family & Carer engagement is key within the Proactive, Safe and Effective Discharge chapter. All units in addition to the Multi-disciplinary team now have a Family/ Carer Ambassador who supports the family/carer voice being heard at key stages of a patient's treatment journey including discharge/transfer.

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. We understand that the Court will share a copy of this reply with Mr Turner's family.

Yours sincerely,

PP [redacted]

Chief Executive