Essex Partnership University
NHS Foundation Trust

23 July 2025

Chief Executive Office
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Wickford
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Tel: 0300 123 0808

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

Dear Ms Hayes,

Nicholas Alan Gray (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 5th June 2025 in respect of the above, which was issued following the inquest into the death of Nicholas Gray (RIP) .

I would like to begin by extending my deepest condolences to Mr Gray'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 the concern raised in the hope that this provides both yourself and Mr Gray's family with comprehensive assurance of changes that have been made at the Trust to address the concern you have raised.

Concern 1) The Trust PSIRF Decision Monitoring Tool completed after Mr Gray died contained inaccurate information, the dates of EPUT contact and the substance of the interactions were inaccurate:

a. Self-harm was noted as "none known or recorded"

b. There was no record of the mental health liaison nurse review on 24 June 2023 and the discharge of Mr Gray from EPUT.

The information used to inform a potential investigation requirement contained significant omissions and was not consistent with the information known to the Trust.

Response

The Trust PSIRF Decision Monitoring Tool (DMT) is designed to be a document which assists the Trust in understanding what type of investigation/learning review should be undertaken following a serious incident. Completion of the DMT is undertaken by a nominated person from the Care Unit where the incident happened. The Trust Patient Safety Incident Team assist the Care Unit in applying the DMT to the PSIRF framework and making the decision on what type of investigation will be undertaken.

The template that was used to complete the DMT in relation into Mr Gray's passing has been reviewed and amended. This was as a result of clinical staff feedback about the template's effectiveness, the risk of duplication and the potential for confusion to be caused.

The new DMT template came into use in January 2024. Since the new DMT template has been in operation, the Trust has not received any further concerns about the accuracy of information and completion of DMTs.

Every completed DMT or investigation now has a Care Unit leadership Multi-disciplinary Team discussion and sign off process. This involves checks and challenges regarding the information provided, decision making and scrutiny of the learning identified. This process provides more robust governance and oversight regarding sign off of a DMT from a Care Unit and Trust wide leadership perspective.

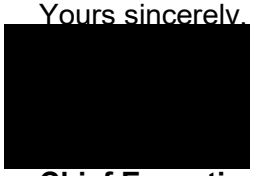
DMTs are also subject to further final scrutiny at the sign off stage by central Patient Safety and by those at Executive Director level.

I hope that I have provided some 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.

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 understand that a copy of this reply will be shared with the family.

Yours sincerely,



Chief Executive