Essex Partnership University
NHS Foundation Trust

02 April 2026

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

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,

Elise Kay Louise SEBASTIAN (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 8th February 2026 received by the Trust on 9th February 2026 in respect of the above, which was issued to Essex Partnership University NHS Foundation Trust (EPUT) following the inquest into the death of Elise (RIP).

I would like to begin by extending my deepest condolences to Elise's family. The Trust sympathises with their very sad loss. The Trust expresses its sincere sympathies and acknowledges the profound nature of their 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 concerns raised in the hope that this provides both yourself and Elise's family with comprehensive assurances of the changes that have been made at the Trust to address the concerns you have raised.

Concern 1
a) Elise was neurodiverse and staff were not trained in Autism

Response:
During the evidence provided at this Inquest, it was acknowledged that the Trust did not have autism training provisions in place at the time of the incident. As part of the learning that has been taken from this case, the 'Oliver McGowan' training module has been implemented at the Trust.

The Oliver McGowan Mandatory Training on Learning Disability and Autism is named after Oliver McGowan, whose death shone a light on the need for health and social care staff to have better training. It is the standardised training that was developed for this purpose and is the government's preferred and recommended training for health and social care staff. There are 2 Tiers, Tier 1 provides training on LD and ASD for those who require general awareness of the support Autistic People or those with LD may need.

For Tier 2 the above is delivered alongside providing direct care and support.

Course outcomes in respect of Tier 2, includes the training on understanding the lives and experiences of people with a learning disability and recognise their strengths and contributions. The training explores factors which impact on the quality of care and support of people with a

learning disability. It aims to develop an understanding on the key findings from the Learning from Lives and Deaths reviews (LeDeR). The objective is to understand what reasonable adjustments are and how to make them. This was introduced at the Trust in June 2023.

In addition to the above training, the Children and Young People's mental health services (CAMHS) have a bespoke CAMHS Autism training which is part of a 4 day specific training module for substantive staff on appointment. Within this training, 2 days are focused on Autism awareness training. This training compliments the Oliver McGowan training (details of this training package were shared during the Inquest).

The Trust has also made environment adaptions for neurodiverse/ autistic patients, with the CAMHS service. Examples include sensory rooms and safe spaces within the High Dependency Unit.

Concern b) Mental health Trust staff on Longfield Ward were inexperienced. The majority were new bank and agency staff with limited experience working with detained children, and this matter had been raised by the Care Quality Commission about other Trust services in January 2021.

Response:
As outlined at the Inquest this Concern was also raised by the Care Quality Commission in a Section 31 issued to the Trust. In order to address this, the Trust developed a CQC S31 Action Plan which was implemented following the CQC inspection (the action plan for which was shared at the Inquest). A number of immediate actions were taken at time (April-July 2021), which included:

- A review of Rotas undertaken to ensure staffing requirements met including right staff with right training and competency skills.
- A process was put in place which allowed staff to be placed on the Unit (bank and agency) who hold the required skills and competencies and who have completed CAMHS induction module. Staff can only book this support if they have completed TASID training; substantive staff receive the CAMHS induction currently.
- The formulation of an enhanced escalation process when roster requirements are not met. This has been shared across all inpatient services.
- The development of ongoing systems to ensure oversight of key competencies, experience, training and skills of all agency and bank staff on CAMHS wards. With self-reporting of this system to the CQC
- The development of an enhanced local induction programme
- The provision of a retention premium for band 5's posts
- The immediate uplift by 1 qualified and 1 HCA per shift
- An enhanced leadership for the CAMHS with the appointment of a new Service Manager for CAMHS and Preceptor support role, these are practice development nurses who support a CAMHS specific preceptor programme.

In addition a further long term improvement plan has been established which includes implementation of activity coordinators, in post on CAMHS Wards from September 2021.

The CQC inspected the service in March/April 2022 and confirmed that improvements had been made including:

"The ward environments were safe and clean. The wards had enough nurses and doctors. Staff assessed and managed risk well and followed good practice with respect of safeguarding."

- Work has continued to develop staff and the CAMHS Preceptorship programme in place, guided practice development framework, led by band 6 practice development role.
- The Service has continued to undertake workforce planning to look at the forward view of staffing needs, impact on skill mix to ensure can respond to children's needs.
- The Trust has introduced the use of the 'Mental Health Optimal Staffing Tool' (MHOST) which is an easy-to-use multi-disciplinary, evidence based system that enables ward based clinicians to:

(i) assess patient acuity and dependency; and
(ii) convert acuity and dependency data into a workload index and required Full Time Equivalents (FTEs) using built-in staffing multipliers to ensure that ward establishments reflect patient needs.

This tool is being used across the Trust.

Concern c) Mental health Trust staff on Longfield Ward**,** did not have sufficient staffing to conduct observations required by the doctors for patients on the ward. This was known to the mental health Trust management and had been raised by the ward manager. During the time of Elise's admission, the staff member allocated for observations for patients was required to conduct approximately 66 observations within an hour. This was not logistically possible. Management knew that staffing allocation on Longview Ward was not sufficient to conduct the required levels of observations to keep the patients safe. Evidence was heard during the inquest that there are still observations that are not being conducted either as required or at all within the Trust and remains an ongoing concern. Datix reporting incidents are not always raised.

Response:
Alongside the assurance set out above, we confirm that as part of the Trust CQC S31 Action Plan, the following actions were taken in April-July 2021:

- In June 2021 the Trust completed the new Engagement and Observation plan for each current inpatient, these were submitted to the CQC
- The Trust undertook a review of shift management and allocation of observations and set principle of no more than 3 patients on level 2 allocated to one member of staff. The Trust continues to adhere to this ratio in CAMHS
- Learning regarding observations was shared at the specialist services quality and safety meetings
- The Trust developed a daily handover checking audit to ensure observations were fully completed during shifts
- The Trust developed an engagement and observation weekly audit tool, which includes a provision for reviewing and monitoring if observations are being carried out in accordance with patient need
- The Trust has added a prompt to the Datix system to prompt a check of observation levels have been undertaken following an incident

- In addition as part of the long term improvement plan the following actions were taken:

(i) Implementation of Positive Behaviour Support Plan (PBS), this includes information
    a. to help staff understanding observation levels and risks and the best ways of engagement with each patient (Aug 2021)

(ii) Reviewed process for updating care plans to show when changes to observation level are made (Oct 2021)

A Trust Observation and Engagement project group was established in 2021 who took forward a number of actions Trust wide. The CAMHS staff were part of this project. Actions included:

- Implementation of electronic observations
- Development of observation and engagement training videos for staff
- Introduction of Engagement and Observation Plan
- A full review of policy and procedures taking into account new guidance CQC

In addition to the above the CAMHS service has further strengthened monitoring and observation processes:

- The Nurse in Charge checks Observations intermittently during the day to ensure completed and takes immediate action with staff where any gaps are found in relation to administrative / recording errors.
- Compliance admin team check all observations for accuracy of completion, for any gaps a Datix incident is raised and the staff member met with and gaps completed.
- Where appropriate staff are referred to Conduct Concerns Panel (CCP). if any gaps are noted in respect of required observations for a sustained period of time (examples of letters issued to staff following missed observations were shared with the Coroner at the Inquest)
- Random checks are completed at handovers
- Trust wide observation audits were added to the Tendable audit system, these have since been combined into Matron and Ward Manager audits
- The Trust continues to create an open and transparent culture encouraging staff to acknowledge if they miss an observation or speak up if they witness an observation missed so appropriate action can be taken to safeguard the patient.
- Introduction of Oxevision gave the opportunity for all staff to be instructed on this system as part of observation handover
- The Nurse In Charge has to give permission for any patients on level 2 or level 3 observation to access their bedrooms
- Morning situation reports to include a conversation around observation levels

Concern d) The mental health Trust implemented a system called Oxevision with a Project Board to assist with the planning and roll out of the new system. There were difficulties with the roll out on St. Aubyns ward who were part of the pilot, due to WiFi coverage and the Oxevision system not operating correctly.

Response:
As covered at the Inquest, during the index period, the Oxevision system was being piloted with roll out being overseen by the Oxevision Project Board (TOR shared at inquest)

As part of the Trust CQC S31 Action Plan the following actions were taken in April-July 2021

- WiFi solution identified by IT, with an additional routers installed (July 2021) Additional tablets were also provided to the ward
- Across the Trust systems have been established to mitigate any internet signal drop out, where staff will revert to paper observation record. This process was witnessed by the CQC at their re inspection in 2022 at CAMHS. Any connectivity issues are urgently reported. The Trust, through Oxevision has an additional safeguard to ensure therapeutic observations.

Concerns e) The clinical management at the Trust Project Board meeting overseeing the roll out for Oxevision, required that ward staff implement a procedure where the Oxevision fixed monitor in the ward office be observed by a member of staff whilst the WiFi problem was resolved. This did not happen on Longview Ward.

Response: Please see below.

Concern f) The Trust Project Group had reports that WiFi was not working and any issues were required to be reported as incident reports on Datix forms but these were not being completed. The Trust Project Board did not question why they were not receiving the Datix forms with the known issues. There was no oversight of what was required to ensure that the roll-out was operating appropriately and/or what the Project Board expected in the interim whilst the WiFi difficulties were being investigated.

Response
As covered during the Inquest, during the index period, the Oxevision system was being piloted with roll out being overseen by the Oxevision Project Board. The terms of reference for this board has been disclosed to the Court).

In response to the above concerns, the Court were assured that between April-July 2021, the following had been actioned:

- WiFi solution identified were acted on at pace by the Trust Information Technology department, with an additional routers installed in July 2021. Additional hand-held tablets were also provided to the ward.

- Across the Trust systems have been established to mitigate any internet signal drop out, with staff being advised on the need to revert to paper observation record in the event that this does occur in order to ensure patient records are maintained. This process was witnessed by the CQC at their re-inspection in 2022 at CAMHS. Again, any connectivity issues are promptly reported and resolved.

It must be noted that Oxevision is assistive technology which "does not alter or diminish" clinicians' responsibilities, and that it is supportive only and must not replace in-person observations or therapeutic engagement. Training is provided on this assistive tool.

Concern g) Not all the Trust staff on the ward were trained to use the Oxevision System.

Response:
By way of assurance, and in line with the evidence provided to the Court during this Inquest, the Trust undertook the following steps as part of the CQC S31 Action Plan over the course of April-July 2021:

- Oxevision SOP approved and circulated to staff
- E-learning Oxevision training to be provided to staff
- Reminder to all staff, including ‘snap comms’, to ensure sound is switch remains ‘on’ for Oxevision
- A Oxevision task and finish group has worked with CAMHS units to understand how Oxevision would work best for them

- Estates solution implemented to stop plug sockets power from being accidently turned off

In addition the Trust has developed of set of competencies for Staff using Oxevision and has implemented Oxevision audits.

Concern h) There was disputed evidence about the volume on the fixed terminal for Oxevision in the office about whether the alert volume could be turned down or 'muted'. It was established that there was an incident unrelated to Elise's death where a doctor did turn this volume down on the ward.

Response
In line with the assurance evidence provided to the Court, and as part of the Trust CQC S31 Action Plan the following actions were taken in April-July 2021:

- Reminder to all staff, including 'snap comms', to ensure the sound is switch on for Oxevision
- Estates solution implemented to stop plug sockets power from being accidently turned off

As per our evidence at this Inquest, configuration changes to the Oxevision system have been implemented. 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 has been undertaken to align terminology and updated versions of the SOPs have been implemented.

Again, 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.

Concern 2
Elise's medication changes whilst in mental health hospital were not correctly entered onto the medication chart:

Concern a) Elise asked for changes to her medication and then reported that these changes were not therapeutic. It was agreed with her consultant that her previous regime would be implemented. The medication was crossed out and removed from the prescription chart. Sertraline 200mg was re-prescribed by the consultant but not entered onto the medication chart and not administered.

Response
The Trust confirms that the medication card was re-written, in line with standard NHS practice; however it was acknowledged that there was an error at this stage made by the person completing the new medication card and one medication provision was missed, whilst this did not have a causative effect to the sad outcome in this case, this was regrettable. The practitioner concerned has reflected upon this oversight.

The Trust has since intruded an electronic prescribing and medicines administration (ePMA) system. This new system provides safeguards around prescribing. ePMA will help prevent inadvertent omission of medicines which could occur when a paper drug chart reached completion and has to be rewritten.

It is not uncommon for a prescription to change and there is clear legislation guiding nursing staff on administration of medication ensuring this is in line with the Prescription Card. Nursing staff cannot administer medication not included on the card.

To strengthen medicines management, medication changes are discussed at the MDT and prescriptions are re-checked during this review.

Medicines reconciliation is undertaken by pharmacy for new patients. Whilst, medicines reconciliation is not relevant in this case, with the issue being the need to ensure that the medicines prescribed on admission, reflect those prescribed pre-admission unless there is an intentional decision to omit something. It is noted that in this case it appears that the reconciliation would have already occurred and would not have changed the medication plan at all.

In addition, Pharmacists review prescription charts for accuracy and completeness, identifying drug incompatibilities, providing advice to the healthcare team and to patients, and assessing the pharmaceutical needs of individual patients. This enables pharmacists to make a comprehensive assessment of medication and individual risk factors, thereby helping to optimise the therapeutic management of each patient.

Concern b) Nursing staff did not query the sudden cessation of medication for treating mental health with no replacement or explanation given. Elise suffered a significant deterioration in her mental health during this time, the frequency and severity of ligatures increased, and Elise had to be placed under section 3 Mental Health Act.

Response
Staff have been reminded via supervision sessions of the importance of applying professional curiosity and challenge as needed.

The process in the medicines policy for the administration of medicines (CLP13 SOP 10) does include taking opportunities to engage the service user in conversation about their treatment, checking knowledge of their medication and offering information and advice about the medicines, which would have been provided for Elise.

Concern c) There was no pharmacist scrutiny just prior to the Bank Holiday and the medication error was only noted when questioned by Elise's family when she went on home leave.

Response
In April 2021 three pharmacist posts were based at Colchester, one of which was vacant, one working from home due to COVID shielding, leaving only one (the most junior) on site. So whilst the clinical pharmacy rota included a weekly visit, that may not have been possible every week.

Now with ePMA in place screening of prescriptions can take place remotely so whilst physical presence of a pharmacist on the ward is still important, options exist when it is not possible. A pharmacist generally visits twice weekly, and also now routinely attends weekly MDT meetings on both wards at the St Aubyn Centre

Concern 3) There was poor communication between ward staff and vital information about self-harm and ligaturing was not handed over on shift change. It was undisputed that Elise tied 12 Ligatures between 7th and 14th April and that she was found in the presence of ripped bedding

on 15 April. The Datix incident recording gave minimal details and only the ligatures from the 13th and 14th were recorded on the whiteboard in the nurse's office.

Response
Risk is based on both level of harm of an incident and number of incidents that have taken place.

Elise had multiple low harm incidents. These were promptly shared with staff and as a result her observations were maintained at levels 2 and 3's in response to the identified risks.

As part of the Trust response to the CQC S.31 Notice, an enhanced ligature analysis was undertaken. This identified that door tops was one of the most used ligature items. A review of the doors urgently undertaken and new doors identified for Longview and Larkwood for bedrooms and corridors. This was completed in November 2021.

The Trust undertook a project as part of a Trust-wide CQC action plan to improve incident reporting (both to ensure all incidents are recorded and to ensure all key information was captured in the incident). Actions taken have included:

- A survey was undertaken with staff to understand barriers in reporting. The outcomes were reviewed revisions made to the incident reporting form both Datix Incident Form 1 and Datix Incident Form 2
- Enhanced systems for ensuring staff review a patient's risk assessment following an incident. This included an added an automatic reminder in Datix prompting staff to review risk assessments.
- Develop and implement process for advertising changes made following incidents
- Implemented automatic feedback from Datix to reporters
- Awareness raising for handlers of importance of completing key fields, which then allows staff to obtain feedback on reported incidents.

In addition to the above the CAMHS has also undertaken dedicated improvement work within their services. This has included:

- Training with preceptor nurses as part of induction
- Involvement in ligature projects, including categorising ligature to indicate level of risk
- All CAMHS Datix incidents are written in ABC format, this promotes learning through DBT – all staff trained in this. This training allows for a clearer understanding of the behaviours before, during and after an incident, and support DBT focused approaches to understanding emotions and identifying linked behaviours in order to make changes through therapeutic interventions.
- All staff asked to complete action taken and this informs chain analysis that is undertaken by staff

The Trust has also implemented changes to handover process using SBAR – an electronic handover system.

Concern 4) Mental Health Trust staff falsified Elise's observation records and this was not identified by the Trust post-death investigation despite the availability of timings from Oxevision imaging. This matter arose in an inquest that significantly post-dated Elise's death and there is concern that lessons had not been learned. The Trust internal investigation does not refer to this and these matters are arising with scrutiny within the inquest hearing.

Response
The investigation followed the Patient Safety Incident Response Framework (PSIRF) approach. This is an overarching framework for how the NHS responds to all patient safety incidents for the purpose of learning and improvement within the Trust. These reports should be shared with carers and families and can be a source of information supplied for the Inquest process.

In EPUT, this is a devolved process where the investigators (Learning Response Lead (LRL)) are members of staff within the organisation carrying out different roles. These reviews are carried out at a point in time with the information that is available at that time. This model was chosen because of the benefits of having staff who understand the service areas but are not involved in delivering care in that area. PSIIs are signed off by the senior management in the Care Unit and Executive colleagues.

Proposed Improvement in PSIIs

- Further develop the support for LRLs ensure that all relevant steps have been taken for example ensuring all relevant Trust documents are included, these documents need to be relevant to the time the incident took place, not the time the report is being written and also be applicable to the area of practice where the incident happened and that all key patient records/documents have been pulled as a data source for the review. Currently the checklist is more general and completed at the end of the review process. This case has identified the need for this to be much more detailed and be used as a guiding framework throughout the investigation.

- Ensure direct confirmation with the care team where the incident has taken place to confirm what documents have been used to guide practice and when and how they have been accessed locally. This is to ensure alignment with those published by the Trust.

- Ensure that there is a mirroring checklist as a quality check to assist sign off by the organisation.

- Explore whether arranging a service lead contact within the relevant area helps the reviewer check information more easily.

Concern 5) The observation level for each young person is decided by the medical staff at the Trust and can be altered dependant on the patient's risk level. The Trust Policy had a protocol on how observations should be conducted. All observations should be recorded by the staff on formal observation sheets. There were sheets for Level 1 and another sheet for the levels 2,3 & 4. Risk assessments were incomplete and not all ligatures were included The entries in the records were not all consistent, some contradicted others and this included the levels of observations required to keep Elise safe on the observation charts that were required to be completed. This was confusing and remains a concern as these are entries made by qualified Trust staff who have received training in observations. During the Trust internal investigation after Elise's death, the investigator visited the ward and found observations were not being conducted in accordance with the Trust Policy.

Response
Please see response to concern 1c

Concern 6) Detained patients including Elise were not kept under observations by trained staff and mealtimes were chaotic with patients moving between areas without the required

supervision. On 17 April the activity co-ordinator left a box of mobile phone chargers and headphones that posed a ligature risk, with a member of ward staff in a communal area, asking that she look after this whilst he collected some takeaway food that had been ordered by patients from the ward entrance. On his return, the box was unattended in the presence of patients with a high risk of ligature and suicide, with no member of ward staff present to keep patients who required level 2 and level 3 observations. This was not reported to the nurse in charge, and no incident report was completed. Evidence was that there were many new staff and that breaches of procedure were a regular occurrence. This left patients at risk. Evidence was heard that patients are still being left without the required observations since this death.

Response
The Trust acknowledges that there are times when observations are not carried out in line with observation prescriptions. This is often down to human error. As outlined above there are robust systems in place to identify missed observations and the onward action that is addressed with staff.

There are a range of potential environmental risks on all wards. The Trust has a set of Environmental Standards to minimise risks and utilise reduced ligature products but it is not possible to eliminate all risks. Part of environmental risk mitigation is the observation level assigned to each person, based on that individual persons risks. Observation is about having a presence and engaging with patients and to empower staff to be curious and knowledgeable of the risks and mindful of the complexities of each individual patient.

As part of ongoing work to make our environments as safe as possible, without introducing restrictive practice, the CAMHS units have introduced communal chargers. Charging points are in place to ensure the safe charging of devices in line with EPUT fire regulations and reduce ligature risk.

Concern 7) Oxevision imaging showed Elise entering her bedroom alone at approximately 18:10 hours and she remained in her room until she was found unresponsive at approximately 18:29. Elise's observation logs for 17:30-18:30 on 17 April were falsified recording that Elise was in the communal area with checks completed at 17:30 17:40 17:50 18:00 18:10 and 18:20 recorded that Elise was present in the communal area. Elise was required to be on constant eyesight observations whilst in her bedroom.

Response
See previous answers re engagement and observation. All requests for patients to access bedrooms are now approved via the Nurse in Charge. However, the Trust acknowledges that these entries were falsified with recording of observations not carried out as required.

Elise was subject to constant eyesight observations when in her bedroom, and this level of care was not provided. The Trust accepts that this represents a serious failure to maintain her safety and a breach of expected professional and organisational standards. The Trust has processes in place to ensure that staff are held to account for their actions. This includes the use of formal internal human resources processes to address misconduct and, where appropriate, referral to the relevant professional regulatory bodies so that they can independently consider fitness-to-practise concerns.

The Trust is committed to ensuring full transparency in understanding how and why patient safety events occurred, to taking appropriate action in relation to staff accountability, and to implementing the necessary improvements to prevent any recurrence

Concern 8) The mental health Trust were on notice that staff must have falsified the observations logs for Elise in 2021. Another inquest for a St. Aubyn's patient who died on 12 July 2022, also found that observation logs were falsified and contained errors. Trust staff falsification of records were not further investigated or monitored after Elise's death at St. Aubyn's Centre.

Response
This concern is factually incorrect, the inquest on 12 July 2022 was for a patient under the care of the Derwent Centre, not St Aubyns.

Please see responses above regarding improvement work for engagement and observation

Concern 9) Elise's key nurse was working nights and was not having the required 1:1 with Elise and key documents were not completed for Elise's care. Inaccuracies and inconsistencies in record-keeping remains a concern.

Response
By way of assurance on this, the Court is advised that all staff are part of internal rotation, which includes nursing staff being rostered to work night and day duties. The night shifts start at 7pm; this enables staff to have 1:1 with patients during the course of the evening. This is often preferable for the young person depending on activities during the day. During the day, the unit provides a full education programme and therapeutic programme outside of education hours. Therefore, spending time with key nurse outside of these hours often means this is quality, uninterrupted time.

Patient's weekly 1:1 with their key nurse is monitored by unit charge nurses, this includes a review of the corresponding clinical records. Issues and concern are shared with the ward manager and all key nurses. The units also have weekly check-ins with family in order to keep families updated and engaged with care planning.

Where gaps are found action is taken to ensure 1:1 are being completed, and where required the 1:1 will be reallocated if a staff member is absence.

The Trust has continued with a Record Keeping Safety Improvement Programme (SIP). This SIP program is focusing on improving patient safety in respect of documentation specifically through education and development of appropriate guidance.

Concern 10) whilst this did not directly cause Elise's death, there were plenty of staff who responded quickly to the emergency when Elise was found unresponsive but there was a delay:

a. bringing the grab bag to this emergency
b. obtaining and attaching the defibrillator.
c. In notifying the duty doctor who was not contacted for over 40 minutes.
d. The expert witness was of the opinion once the defibrillator was attached, it was being switched on and off in the first few minutes. When looking at the machine analysis there appeared to be 3 analysis checks on the machine within the first few minutes when the machine is set to conduct analysis at set intervals which is inconsistent with this.

Response:
As per the evidence provided to the Court, in line with the safety actions undertaken by the Trust following the CQC S.31 Notice, the following was put into place during April-July 2021:

The Trust has made the decision to deliver the 'gold standard' Resuscitation Council UK Immediate Life Support (RCUK ILS) training to all registered nursing staff working within an inpatient setting. RCUK ILS training was rolled out from September 2022. The one day face to face training is accompanied by a RCUK ILS 'hard copy' training manual and is delivered on an annual basis.

The RCUK ILS training focuses upon the identification and treatment of the deteriorating patient, using a structured and robust ABCDE assessment and non-technical human factors skills, such as team working and leadership during a medical emergency. By following this structured approach, staff are equipped with the skills to try and prevent deteriorating patients from reaching the point of cardiac arrest, and are trained in the interventions available at each step. The course follows the latest RCUK guidelines.

Non registered staff working within an inpatient CAMHS setting, receive annual, face to face Basic Life Support training.

The 'Assessing a Critically Unwell Patient' Aide memoir document has been implemented within EPUT. The aim of the document is to help identify the deteriorating patient, treat and stabilise in order to prevent cardiac arrest and the resus bag will be taken to every unwell patient if an alarm is raised. The tool acts as an aide memoir to support the team carrying out the physical health assessment of the unwell patient. The aide-memoire must be located within the resus bags on the wards, so staff have easy access to the guidance during a medical emergency.

The 'Non-touch physical observation' tool provides staff with an opportunity to observe patients' vital signs in a non- intrusive way and provides a guide when to escalate, if there are any concerns in relation to the parameters. The tool was piloted on selected inpatient wards, before being rolled it out across within the Trust. This use of this tool has a wealth of patient safety benefits, especially where physical examinations are not possible or would be disruptive to patients. Guidance relating to the use of the tool is provided within CG52 Clinical Guidelines for the Pharmacological Management of Acutely Disturbed Behaviour and CG87 Clinical Guidelines on the Use of National Early Warning Scoring System (NEWS2).

The use of the 'Calling (9)999 in a Medical Emergency' document was developed, implemented and shared as an EPUT Internal Safety Alert on 1st June 2023 (INT LL 2023 002) , following lessons identified and provides information for staff when calling (9)999, including a prompt for staff, to meet the Ambulance crew and facilitate access to the site. This poster is now displayed within the ward and a copy must be stored within the front pocket of the resus bag,

The above tools were highlighted within an EPUT Lessons Team 'Learning Matters' live event, which focused upon assessing deterioration patients and resuscitation, which was facilitated on 25th June 2025.

The Head of Deteriorating Patient Pathways and Resuscitation Training Officer and The Head of Clinical Transformation have facilitated life support drop in refreshers sessions for EPUT staff working within a CAMHS setting. These sessions are an opportunity for staff to refresh their knowledge of BLS/ILS in small groups, in between their mandatory training sessions, including refreshers on topics such as chest compressions and airway management.

The Essex Partnership NHS Foundation Trust's CPR procedure document (CLPG14A) states the Ward Manager, Matron or Service Manager/Clinical lead for each inpatient setting, will be responsible for ensuring that medical emergency simulations are undertaken every three months in the clinical environment. Each inpatient setting must record when a medical emergency simulation is facilitated, using the approved 'Medical Emergency Simulation Practice Report'

document. In addition the facilitation of the medical emergency simulation can be supported by the allocated Professional Nurse Educator or Resus Link Practitioner.

The Trust has also introduced the role of Resus Link Practitioners (RLP) to all inpatient ward settings. These volunteers will play a key role in strengthening the response to medical emergency situations within the wards. The role is open to all nurses and HCAs/support workers and the RLP will act as a link between the Resuscitation and Deteriorating Patient Group and their ward, promoting best practice and raising awareness. The RLP will:

a. help facilitate medical emergency simulations on their ward;
b. have access to a fully-stocked resus bag (which itself is checked weekly by nursing staff) and training mannequin to help train staff;
c. help ensure all ward staff know what emergency equipment is on the ward, where it is, how to use it, and the importance of checking it regularly;
d. update colleagues on key life support messages and training;
e. participate in audit data collection; and
f. attend bi-monthly Resus Link meetings, where important Resuscitation Council UK updates are shared, medical emergency simulation outcomes are discussed and RLP have a chance to raise any questions.

The RLP role allows staff to build upon and enhance their own expertise, while having the ability to coach and empower their team, in order to be ready to respond quickly and effectively, in any medical emergency situation.

In summary, risk assessment at the Trust have moved away from RAG rating and become more descriptive. This is part of the Trust move towards personalised risk assessment and safety planning in line with NICE guidance.

Risk assessment and care plans aim to be holistic so we would not necessarily have separate documents for all risks/needs but a separate assessment and plan would be considered for significant risks, work remains ongoing to ensure this revolving and ongoing duty is refreshed daily and given priority.

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

Yours sincerely

[redacted]
Chief Executive