Witness Name: Paul Scott

Statement No: 1

Dated: 20 March 2025

Rule 9 reference: EPUT Rule 9(14)

LAMPARD INQUIRY

FIRST WITNESS STATEMENT OF PAUL SCOTT

I, Paul Scott, will say as follows: -

Introduction

1 I am the Chief Executive Officer within Essex Partnership University NHS Foundation Trust ('EPUT') and I have held this position since October 2020.

2 I have been in employment with EPUT since October 2020.

3 This statement is made in response to the request by the Inquiry to EPUT on 31 January 2025, under Rule 9 of the Inquiry Rules 2006, with reference **'EPUT Rule 9(14).'** EPUT was asked to provide information related to the previous Health and Safety Executive ('HSE') prosecutions against EPUT and its predecessor organisations. Other than the HSE prosecutions in 2014 and 2020, EPUT is not aware of any other prosecutions against EPUT or its predecessor organisations since 1990.

4 I recognise the contents of this statement relates to extremely difficult circumstances for the families involved who continue to feel the impact of these sad events. This statement details the facts related to the prosecutions in order to support the Inquiry. However, no part of this statement is intended to diminish in anyway the tragic loss of life and the ongoing suffering of the families, which is recognised by EPUT and its staff.

5 My statement will be set out using the following structure:

a) Background and summary of the 2014 prosecution

b) Background and summary of the 2020 prosecution

c) Action taken by EPUT

d) Impact on EPUT of the proceedings

Background and summary of the 2014 prosecution

6 EPUT holds limited documentation in respect of the 2014 HSE prosecution due to the time that has passed. The account in respect of the 2014 HSE prosecution below is taken by me from the written material in EPUT's possession and represents a summary of key information contained in those papers. I do not have any first-hand account knowledge of these matters, and I am reliant on the papers to set out this account. The facts as stated below, is the position of the NEP as set out in their response to the HSE's case (**Exhibit PS-003b PART 1 –** [I/S] **Response to 'Friskies' Schedule & Summary of Mitigation)**.

7 The case involved former North Essex Partnership University NHS Foundation Trust ("NEP") and the failure to protect service users at the Derwent Centre from falls from windows which were not adequately restricted from opening.

8 [I/S] the patient involved in the case was admitted to the Derwent Centre on [I/S] 2013 via the Emergency Admissions Unit. She was risk assessed and prior to the accident had not exhibited any behaviour which indicated a desire to self-harm or abscond and there was no indication of any increased risk.

9 I understand from the case papers that following admission a care plan was prepared and [I/S] was placed on Chelmer Ward. In the past, [I/S] had attempted to abscond through the door as the most obvious way out but she had never attempted to abscond via the windows. The NEP papers confirm that [I/S] was placed on level 2 observations (at least 4 times per hour). During these observations and as documented , staff recorded that she engaged well and was the best they had seen her; she was described as euthymic and there was no reason to believe that she was at increased risk of self-harm.

10 On [I/S] 2013, another service user approached a staff nurse for assistance. The staff nurse went to the dormitory where [I/S] had been accommodated to find another service user holding onto [I/S] hands as she dangled from the window. The staff nurse immediately activated her pin-point alarm. The other service user let go of [I/S] who had appeared to be wriggling to get free and [I/S] fell to the ground outside. The staff nurse organised for an ambulance to be called and ran outside to find [I/S] lying on the ground, conscious but in pain.

11 [I/S] was taken to A&E at the Princess Alexandra Hospital where she was treated [I/S] . [I/S] subsequently returned to Chelmer Ward where she once again attempted to climb through a window. This attempt was unsuccessful as the window had by that time been restricted, so that it opened no more than 100mm.

12 NEP's internal investigation found that [I/S] had received a high standard of care but that outstanding work with respect to window restrictors needed to be completed as a matter of urgency.

13 Prior to the incident, guidance and health alerts had been issued relevant to the issue of window restrictors:

a) Health Technical Memorandum ("HTM") 55 set out guidance with respect to new building work for health buildings and recommenced that new or replacement windows within reach of patients should not open more than 100mm, particularly in areas for the

elderly, those with learning disabilities, mental illness and for children. For completeness, post incident, HTM55 was replaced in December 2013 with Health Building Note 00-10. This guidance was specifically targeted at project and design teams and those responsible for construction, commissioning and maintaining health buildings.

b) On 31 October 2007, the Department of Health issued an Estates and Facilities Alert (DH(2007)09) which recommended that trusts revisit the details of HTM55. The intention of the alert was to update HTM55 and recommended trusts should assess the need for window restrictors in those patient locations where none existed. There was not a specific requirement that restrictors be fitted.

c) On 19 January 2012, the Department of Health issued Estates and Facilities Alert (EFA/2012/001) which dealt specifically with restrictors with plastic 'spacers' which could deteriorate.

d) On 23 January 2013, the Department of Health issued Estates and Facilities Alert (EFA/2013/002) in response to an incident where a patient had forced open a window which had been restricted. It required an inspection of all windows by May 2013 and consideration of the replacement of existing restrictors.

e) Other guidance was referenced during proceedings, but these were not relevant to the NEP e.g. HSG220 which dealt with health and safety in care homes and SIM07/07/2007/07 which was intended for the use of regulators such as HSE and local authorities.

14 As part of the subsequent investigation by the HSE, the then Chief Executive Officer (CEO) of NEP, Mr Andrew Geldard, attended an interview under caution as the representative for NEP on 19 December 2013 **(Exhibit PS-001: Transcript of interview under caution)**. On 24 April 2014, NEP received notification from the HSE that information had been laid before the Court and NEP was issued a summons to attend a hearing on 30 May 2014 **(Exhibit PS-002: Letter from HSE enclosing summons; HSE case summary; and bundle of HSE statements)**.

15 Following the completion of the investigation by the HSE and notification of the charge, NEP pleaded guilty and accepted, as part of the basis of its plea, that some windows within the patient areas of the Derwent Centre were not restricted in line with the recommendations set out in HTM55 (as applied by subsequent guidance) and that following receipt of DH(2007)09 there was no evidence of a review taking place by the maintenance contractors from Princess Alexandria Hospital, although NEP had

disseminated that alert. On that basis, NEP accepted that whilst it did not ignore or fail to act on DH(2007)09, it failed to ensure that its contractors at the time carried out the assessment of window restrictors and had in place a system of planned periodical audit/maintenance to ensure continued compliance. NEP's Health and Safety Plan and planned preventive maintenance was a common feature of the Estates Department system but this did not include window restrictors. **(Exhibit PS-003a – PS-003ad: HSE v NEPFT Defence Bundle, Index and Parts 1 – 20- provided as received in 31 separate pdf documents due to size of bundle).**

16 NEP did highlight as part of its mitigation during sentence that prior to the incident a number of actions had taken place in respect of window restrictors. A survey of the Derwent Centre prior to NEP taking ownership did not highlight concerns with window restrictors. Following the 2012 alert, the Estates Department undertook an evaluation of the windows in line with the concerns in the alert but this did not extend to consideration of the relevant gaps created when the windows were opened, the alert itself only requiring hospitals to look at the plastic spacers. Following the 2013 alert, NEP did take appropriate action to audit compliance within the timescale but the incident occurred during the period where NEP was in the process of upgrading restrictors. Whilst there were restrictors in place and work was being done at the time of the incident to address the risk, NEP accepted that the work could and should have been done sooner.

17 Following the incident, NEP undertook the following actions:

a) Completed the installation of 100mm window restrictors;

b) Introduced daily "site wide" window inspections by the clinical staff;

c) Completed a Patient Safety Audit (September 2013) during which all windows/window restrictors were inspected;

d) Introduced a robust recording and reporting system;

e) Ensured a rapid response to reported window defects;

f) Ensured planned and preventative maintenance tasks were in place;

g) Introduced Estates staff attendance at patient safety audits to ensure a qualified assessment on all issues from an estates perspective; and

h) Improved communication between clinical and estates staff, particularly concerning anxious and agitated service users and the challenges they provide.

18 On 21 October 2014, NEP was convicted at Chelmsford Magistrates Court of an offence under section 33 of the Health and Safety at Work Act 1974 ("HSWA") in that between 1 July 2011 and 27 July 2013 it breached the duty under section 3 of HSWA by failing to protect service users at the Derwent Centre from falls from windows which were not adequately restricted. NEP was fined £10,000 and ordered to pay costs.

Background and summary of the 2020 prosecution

19 In 2016, Essex police began an investigation into patients who had died whilst in hospital whilst under the care of NEP. Members of the Interim Board for EPUT only became aware of the Police investigation a couple of weeks prior to the merger of the two organisations. Once aware, a small project team was established to support requests from Essex Police. Initially the police investigation covered a number of incidents but as the investigation progressed it moved to become a corporate manslaughter investigation.

20 EPUT was informed that there were a number of individual patient cases that the police subsequently advised were outside of the scope of their investigation either because they were a community patient (and Essex Police were focused on inpatient cases) or that they fell outside of the initial scope of the investigation [I/S]

21 Whilst the police investigation took primacy, the Trust was informed that the Care Quality Commission and HSE were aware of their investigation. The EPUT project team provide a wide range of documentation and information to support the police in their investigation. The police investigation concluded in November 2018 with no charge against the Trust and the matter was then formally handed to the HSE to continue its investigation as the lead regulator at the time of the incident.

22 The HSE investigation (and subsequent prosecution) related to in-patient ward environments under the control of NEP prior to its merger with South Essex Partnership University NHS Foundation Trust (SEPT) and the creation of EPUT. Criminal liability for the former Trusts was assumed by EPUT at the point of the merger (1 April 2017) hence EPUT remaining criminally liable for any offenses committed prior to the merger. The investigation focussed specifically on the management of fixtures from which ligatures could be attached. Nigel Leonard, Executive Director of Corporate Governance was the individual within EPUT responsible for providing direction and instruction to the internal EPUT legal team during the investigation and subsequent prosecution. This was managed with the oversight of myself in my role as Chief Executive Officer following oversight from the previous Chief Executive, Sally Morris. Again, whilst EPUT responded to the

prosecution and was the Defendant to it, the information in this Statement about the patient deaths and 'near-miss' on which it was based is derived from NEP papers, and it is this material which I have summarised below.

23 The HSE investigation focused on 11 in-patient deaths and one near miss event using a fixed point of ligature within the ward environment in NEP (between 2004-2015 **(Exhibit PS-004a – PS-004k: Datix incident records).** The details of each case are summarised below, focussing on the elements that relate to the issues at the centre of the HSE prosecution, (i.e., the management of fixed ligatures). Each case was reviewed by NEP as part of a serious incident investigation, in some cases via an initial 7-day report before a more detailed extensive panel report was completed. The full serious incident internal investigation panel reports and action plans for each case are located within the HSE bundle detailed in point 29 below **(Exhibit PS-009**: **HSE Initial Details bundle)**;

a) DG – date of death 25 October 2004 following an incident at Galleywood Ward, Linden Centre having hanged herself in her bedroom [I/S] . The NEP internal investigation noted that the overall aim to reduce the risk of self-harm was evident throughout the care provided and the observation levels reflect and were responsive to her changing needs during her admission. However the panel noted some concerns that the method used by DG was consistent and this was why access to electrical flex on a number of occasions was investigated and items removed. [I/S] Actions taken following this incident included the removal of the door closures.

   To the best of EPUT's knowledge and belief, no civil claim was received by NEP in respect of DG.

b) FP - date of death 4 December 2004 on Gosfield Ward, The Lakes. He had been detained on Gosfield Ward under Section 3 of the Mental Health Act 1983. At the time of his death he was subject to 15-minute checks as detailed in the Observation Policy in place at that time. He was found to have taken his own life by hanging [I/S] .
   The NEP internal investigation found that a ligature point audit had been carried out on the ward and a ligature point was identified and an action plan was developed. The ligature point was not removed as part of the remedial work until after the incident. The panel found that no omission or action contributed to incident. His care and treatment offered was appropriate, during a sustained in-patient episode, was clearly identified

and managed. The NEP panel also determined the standard of recording of decision making, documentation of risk and progress/management plans was good.

To the best of EPUT's knowledge and belief, no civil claim was received by NEP in respect of FP.

c) EJ – date of death 31 December 2007 on Maple Unit, Severalls Hospital. He had been found hanging [I/S] . The NEP internal investigation report, noted that EJ had made previous attempts with a ligature [I/S] and raised concerns about the confusing and contradictory evidence received about risks and audits and a lack of records regarding concerns which were raised other than the audits, despite various members of staff giving evidence that they had raised concerns [I/S] . The panel recommended that NEP should address the issue of outside specialist training for those employees undertaking the task of environmental risk assessment to enhance knowledge and skills in this area. The internal investigation recommended that the ward environment should be assessed for risk on a regular basis specifically for ligatures, including actions to ensure robust reporting and the keeping of written records.

To the best of EPUT's knowledge and belief, no civil claim was received by NEP in respect of EJ.

d) BM – date of death 28 December 2008 on Galleywood Ward, Linden Centre. He was found in his room on the floor having hanged himself [I/S] . Staff dialled 999 and attempted to resuscitate BM but this was not successful. The internal investigation noted that the risk from handles had been identified in the audit of September 2007 but was categorised as "low risk" when the wardrobes were freestanding. An action had been raised to replace the handles, but this had not been carried out. The wardrobes had subsequently been secured to walls which meant they no longer toppled if used as a ligature point. No re-assessment of risk was completed following this change even though this removed the potential for the wardrobe to topple increasing the risk of the handle being used as a fixed ligature point. The panel recommended that NEP implement a system to re-assess risk where modifications were made to items identified as a risk. In addition, the panel recommended that there be monthly environmental meetings with the Risk Management Department and feedback on audit findings.

To the best of EPUT's knowledge and belief a civil claim was made in respect of BM which was settled on 5 September 2011.

e) [I/S] – date of death [I/S] 2009 on Peter Bruff Ward, Landermere Centre. [I/S] was an informal in-patient at Peter Bruff Ward when he was found hanging [I/S] by a member of staff. The internal investigation report recommended that a review of the potential use of bedroom wardrobes as ligature points be undertaken to ensure that future risk was minimised.

To the best of EPUT's knowledge and belief, a civil claim was made in respect of [I/S] and was settled [I/S]

f) [I/S] date of death [I/S] 2010 on Ardleigh Ward, The Lakes. [I/S] was found hanging in his bedroom. [I/S] In the internal investigation report, the panel stated they were satisfied that the design of the window and layout of the room did not in themselves present a specific or significant risk but that it may be necessary to revisit the unit risk assessment with Risk Management for clarification. The internal investigation report recommended that the Risk Management Team consider a review of the Unit Risk Assessment at the Lakes for clarification and advice.

To the best of EPUT's knowledge and belief, no civil claim was received by NEP in respect of [I/S]

g) SO – date of death 1 April 2012 on Ardleigh Ward, The Lakes. At 8.10am, SO was found hanging in his bedroom. [I/S] He was transferred to Colchester general hospital via ambulance and unfortunately was pronounced deceased. The internal investigation noted that annual ligature audits were being conducted and should continue.

To the best of EPUT's knowledge and belief, a civil claim was made in respect of SO and settled on 3 April 2016.

h) ML – date of death 15 November 2012 on Galleywood Ward, Linden Centre, he was found hanging in his room [I/S], he was then transferred to Broomfield Hospital where he was pronounced deceased. The type of hinge had been identified some years before ML's death and had been identified as 'high risk' in the previous year's audit. The NEP internal investigation recommended that risk relating to door hinges should be thoroughly revised to prevent recurrence of a serious incident.

Following the Inquest into the death of ML, the Senior Coroner for Essex made a Regulation 28 Action to Prevent Future Deaths report ("PFD") on 1 June 2015 in respect to two areas of concern which did not relate to the management of fixed ligature risks. Full details of this report are included in the Trusts statement submitted for Rule 9(7a).

To the best of EPUT's knowledge and belief, a civil claim was made in respect of ML and was settled on 20 April 2016.

i) IS – date of death 1 March 2014 on Ruby Ward, Crystal Centre. IS was found hanging [I/S] The internal investigation report recommended consideration of improving the anti-ligature design of the door [I/S], such as a curved top edge, a panel above the door which would "pop out" under pressure or a load release mechanism on the latch. The panel also found that there was a lack of staff awareness of risk assessment and risk management in relation to environmental factors demonstrated in interviews.

To the best of EPUT's knowledge and belief, a civil claim was made in respect of IS which was settled on22 January 2019.

j) [I/S] date of incident [I/S] 2015 on Finchingfield Ward, Linden Centre. [I/S] was found unconscious in the bathroom when a staff member completing checks noticed a tied knot [I/S], he was then transferred to Broomfield Hospital where he was pronounced deceased [I/S]. The internal investigation recommended that all the equipment provided within the shower and bathrooms across NEP be thoroughly reviewed, such as shower curtains and bins, to see if any possible alternatives could be sourced that would reduce the risks of an incident occurring again.

To the best of EPUT's knowledge and belief, a civil claim was made in respect of [I/S] which was settled [I/S]

k) [I/S]– date of death [I/S] 2015 on Gosfield Ward, The Lakes. [I/S] was found in the toilet of the ward [I/S]. The internal investigation found that the existence of an unsecured loft hatch in a private area was contrary to national guidance. Staff had also been unaware of this environmental risk, and there had been a failure to communicate risks properly.

The internal investigation report recommended that NEP should ensure more efficient distribution and actions from audits, and that steps should be taken by the estates department to manage the risk of loft hatches across NEP.

Following the Inquest into the death [I/S] the Senior Coroner for Essex made a PFD report [I/S] in respect of concerns not related to the management of fixed ligature risks. Details of this is included in statement for Rule 9(7a)

To the best of EPUT's knowledge and belief, a civil claim was made in respect of [I/S] which was settled [I/S]

l) Near miss incident

A near miss incident occurred on [I/S] 2013 at Ardleigh Ward, the Lakes. A patient was found hanging [I/S] The patient [I/S] survived the incident. An internal investigation was completed and noted that a similar incident involving the same patient had occurred a few days earlier but it did not appear to have led to a formal report being completed [I/S]
Testing following the incident identified problems with other rails which would not collapse (particularly in respect of curved shower rails).

(Exhibit PS-005a-f: Records of Inquest for [I/S] EJ, [I/S] ML, SO and IS). EPUT is unable to locate the Records of Inquests for the other cases currently.

24 On 12 July 2019, the HSE wrote to EPUT and advised that its investigation had identified breaches of duties under Section 3(1) of the HSWA and invited EPUT to provide a written response under caution to the HSE. This letter set out details of the potential charges being considered and a summary of the evidence the HSE had collated **(Exhibit PS-006: Letter from HSE dated 12 July 2019)**.

25 EPUT provided written responses to the HSE dated 4 November 2019, addressing the charges and evidence set out in the appendix to the letter of 12 July 2019 along with a cover letter making submissions in respect of HSE taking enforcement action **(Exhibit PS-007: Cover letter and written response to HSE)**. EPUT accepted at that time that processes and procedures within NEP had not been sufficient.

26 On 20 December 2019, the HSE wrote to EPUT to confirm it intended to proceed with a prosecution against EPUT, having considered the evidence and submissions made by EPUT. **(Exhibit PS-008: Letter from HSE to EPUT dated 20 December 2019)**.

27 EPUT was charged on 19 September 2020 with failing to discharge the duty imposed by Section 3(1) of the Health & Safety at Work etc. Act 1974 in that it failed so far as reasonably practicable, to manage the environmental risks from fixed ligature points within its inpatient wards across various sites under its control in Essex, thereby exposing vulnerable patients to the risk of self-harm by ligature contrary to section 33(1)(a) of the Act. This charge related to the period from 1 October 2004 to 31 March 2015.

28 The key prosecution documents are found within the Initial Details of Prosecution Case ("IDPC") bundle and the key defence documents are found within the Defence Mitigation Bundle.

29 The HSE provided its Initial Details of Prosecution Case ("IDPC") bundle including its Case Summary, providing the details of the HSE case and the evidence relied upon by the HSE including witness statements and exhibits **(Exhibit PS-009: HSE Initial Details bundle)**.

30 The full IDPC bundle was provided in Parts 1-6 and consisted of:

a) Part 1: Information and Summons;

b) Part 2: Case Summary and Sentencing Schedule:

c) Part 3: Witness statements:

[I/S]

[I/S]

d) Part 4: Exhibits – a detailed index of the exhibits can be found at pages 1-7 of Part 4 of the IDPC bundle, but in summary this included:

30.d.1 SUI reports for the 11 individuals referred to at paras 23a) – k) above, as well as a near miss incident and the action plans developed following those incidents (note the SUI reports were redacted for the prosecution case).

30.d.2 Patient Safety Environmental Audits for the relevant wards during the period of charge;

30.d.3 Patient Safety Environmental Standards during the period of charge;

30.d.4 Trust policies on the management of suicidal service uses, services users who self-harm, management of ligature risks etc;

30.d.5 Patient Safety Audits;

30.d.6 Paperwork around the maintenance and work done on various wards e.g. replacement blinds, pelmets, privacy rail;

30.d.7 Timeline of major anti-ligature works since 2010;

30.d.8 Details of Patient Safety and Environment Remedial Works Program as at 7 June 2017;

30.d.9 Trusts Capital Programme 2010-2011;

30.d.10 CQC inspection reports.

e) Part 5: Previous Conviction – a print out of the record of the previous conviction

f) Part 6: Sentencing Definitive Guideline.

31 The HSE stated that the evidence available demonstrated a clear risk to the health and safety of those not in the EPUT's employment – the patients. The fact that patients died as a result of fixed ligatures was relevant to sentencing, albeit the offence charged did not require the prosecution to prove that injury resulted and there was no need to prove causation. The deaths showed the existence of the risk. Having proved the existence of the risk, it was then for the defendant to prove that it was not reasonably practicable to do more than was done to mitigate the risk. As the successor organisation, EPUT accepted

that the predecessor organisation (NEP) did not take all reasonably practicable steps to mitigate the risk to patients in its care from ligature points. Beyond the 11 cases referred to above, the HSE stated that the evidence, particularly the SUI reports, supported that there were multiple occasions over the charge period where incidents involving ligatures occurred but did not result in death albeit it did not hold statistics about the number of incidents. Therefore, the HSE's case was that there was a further risk existed within NEP's premises to other patients during the period which formed the basis of the charge.

32 The HSE referred to a wide range of guidance and alerts that put NEP on notice of the risks presented by fixed ligature points and the need for action to be taken to remove them. The HSE asserted that such steps as were taken by NEP were inadequate and failed to mitigate the risks of fixed ligature points. Specific failings identified by the HSE were:

a) Flaws in the SUI reports - for example, they did not follow a set pattern, were inconsistent, and did not always reference previous audits or environmental issues. The HSE stated that the majority of SUI reports did not result in the necessary reduction of risk from ligature points – i.e. either the reports were inadequate or recommendations were not followed.

b) Patient Safety Environmental Audits - no formal training was provided to those conducting ward audits in around 2012/2013, with no standards or guidelines for training for the ligature audit. The majority of issues identified related to fixed ligature but despite this the same risks were recorded on an annual basis with no identified action having been taken to reduce the risk. Other issues identified from the audits were:

    32.b.1 Numerous occasions where a risk was not assigned a risk level despite the audit calling for one to be assigned

    32.b.2 No control measures identified in the audits, despite them calling for control measures to be identified.

    32.b.3 Where a risk level was assigned, it was often inconsistent with audits on other wards.

    32.b.4 Risk levels changed from one year to the next, despite no changes having been made or additional control measures being identified.

    32.b.5 The same risks appeared in multiple locations.

32.b.6 Action not being taken to address risks, even where the necessary action would be relatively simple.

32.b.7 Action not having been taken to address risks which had previously played a part in patient deaths.

c) Repeated failures of the Annual Patient Safety Audit Reports. A failure to act with sufficient speed, or put sufficient resource into resolving the issues, led to the same actions being identified on a repeated basis. Risk levels of wards did not reduce over time.

d) In addition to the above, the HSE relied on findings during CQC inspections, regarding the management of ligature risk from 2013 onwards. This included the assertion that the need to issue requirement and warning notices demonstrated that by mid-2019 the Trust had not yet taken sufficient action to remove the risks from ligature points across its estate.

33 At an initial hearing on 20 November 2020, EPUT entered a plea of guilty to the charge contrary to section 3(1) and 33(1)(a) HSWA at the Chelmsford Magistrates Court before District Judge John Woolard. District Judge Woolard determined, and it was agreed by all parties, that the powers of sentence available to his court were insufficient to deal with an offence of this seriousness. Accordingly the case was committed to the Crown Court for sentence with a direction that it should be referred to the Presiding Judge.

34 Both the HSE and EPUT commissioned reports from an independent expert. [I/S] On submission of those reports, it was directed by the Judge (and agreed by the parties) that both experts should meet to prepare a joint report setting out the areas of agreement and disagreement between the two experts to assist the Judge during the sentencing exercise. The output of that exercise was included in both the HSE's prosecution sentencing bundle and EPUT's defence mitigation bundle (both referred to below). Dr [I/S] agreed ligature risks were not always managed sufficiently well by NEP but drew attention to the presence of appropriate risk management systems and procedures. He also commented that the evidence should be considered in the context of the clinical and operational complexly of providing inpatient mental health services. Both experts recognised that there were no clear local, regional or national benchmarks to compare NEP's performance in managing its environmental ligature risks. The areas of disagreement between the two experts largely fell within the assessment of the level of culpability and likelihood of level of harm risked, which were specific considerations within

the relevant sentencing guideline. The experts noted that those matters were ultimately for the Judge to determine and was outside their remit of expertise.

35 Ahead of the sentencing hearing, the HSE and EPUT shared their bundles for use during the hearing.

36 The HSE's sentencing bundle **(Exhibit PS-010: HSE v EPUT Prosecution Sentencing Bundle and Exhibit PS-010a additions to Prosecution Sentencing Bundle which were served after the initial Prosecution Sentencing Bundle)** included:

a) Prosecution sentencing opening – summary of their position as above in their case summary;

b) Initial expert report of Dr [I/S] dated 17 January 2020;

c) Additional expert report of Dr [I/S] dated 29 March 2021;

d) Joint expert report dated 19 May 2021;

e) Summons for previous conviction on 21 October 2014;

f) Prosecution bill of costs;

g) Family preferences document;

h) Victim Personal Statement – not to be referred to or read out;

i) Victim Personal Statements – to be read out;

j) Prosecution bill of costs (final);

k) Victim Personal Statement – not to be referred to or read out.

37 EPUT's mitigation bundle **(Exhibit PS-011: EPUT Defendant Mitigation Bundle) included:**

a) Statement of Chief Executive Paul Scott dated 24 May 2021;

b) Summary of Mitigating features and appendix;

c) Statement [I/S] in respect of Trust finances dated 27 May 2021;

d) Expert interim report of Dr [I/S], Consultant Forensic Psychiatrist dated 8 February 2021;

e) Expert additional report of Dr [I/S], Consultant Forensic Psychiatrist dated 4 May 2021;

f) Joint expert report dated 19 May 2021 – table setting out the areas of agreement and disagreement between EPUT's expert (Dr [I/S]) and Dr [I/S] (HSE's expert);

g) Submissions concerning the Definitive Guidelines – Health and Safety Offences;

h) Exhibits to the statement of [I/S] namely:

37.h.1 Accounts 2019/2020;

37.h.2 Accounts 2018/2019;

37.h.3 Accounts 2017/2018;

37.h.4 Table of EPUT underlying performance;

37.h.5 Summary of NEP financial position in the years up to the merger;

i) Fee For Intervention invoices from November 2019 and January 2020;

j) Case law:

37.j.1 BPS Advertising Ltd v London Borough of Barnet [2006] EWHC 3335;

37.j.2 HSE v NHSLA and another Ruling on Costs – Preston Crown Court 7 October 2015 HHJ Baker.

38 The sentencing hearing was held on 16 June 2021 at Chelmsford Crown Court by Mr Justice Cavanagh. In summary, the Judge noted that:

a) The risk of suicide attempts using ligature points in mental health wards was foreseeable.

b) In respect of preventative measures, the Judge recognised that it is not realistically possible to completely eradicate the risk of suicide attempts by hanging and that the provision of inpatient mental health services is clinically and operationally complex. Nonetheless, he noted, it is well recognised that the identification and removal of ligature points is a key step to reduction of suicide risks.

c) NEP was aware of the importance of removing ligature points and other risks.

d) NEP took steps during the period 2004-2015 to reduce ligature points, but the steps were inadequate and in particular the PSE audits were flawed and ineffectual – both in identifying ligature risks and ensuring action was taken to remove them. For example, risks were identified but no action identified, risks were not assigned a risk level or the same risk was assigned different risk levels at different locations. Numerous failings to complete recommended actions to reduce risks were being highlighted on a repeated basis. Those carrying out the audits did not have formal training to assist them in identifying ligature points and there was a lack of training for checking shower rails were collapsible.

e) Internal investigations did not follow a set pattern, were inconsistent and did not always contain reference to previous audits or environmental issues. Opportunities to learn and to put preventative measures in place were lost. The number of incidents that took place during the period of the charge should have triggered greater concern and a more proactive response. Whilst some of the investigations highlighted more preventative work could have been done and drew attention to defects in the anti-ligature work that was being done, the problems continued, and the recommendations were not acted on.

f) The Judge noted that some concerns around ligature risk had come up in subsequent CQC inspections in 2017 and 2018 but that improvement in this respect was noted in the 2019 inspection. The Judge also recognised the evidence provided on the work done by EPUT and the future plans by noting that he was satisfied that matters had improved since and that things were moving in the right direction.

(Exhibit PS-012: Sentencing Remarks)

39 The Judge found high culpability, 'level' A harm and high likelihood of harm arising. The offence exposed a number of workers or members of the public to a risk of harm.

40 The total final was £1,500,000 plus prosecution costs of £86,222.24. The Judge ordered that the fine could be paid in equal instalments over 5 years. EPUT paid instalments of £300,000 in March 2022, March 2023 and March 2024 and in February 2025 processed the fourth instalment. The final instalment is due March 2026.

Actions taken by EPUT

41 As referenced above, in respect of the 2020 prosecution, for each case involved, actions were identified by NEP as part of each internal investigation report (also known as SUI reports). The actions plans for these are included in the HSE's IDPC bundle **(Exhibit PS-**

009: HSE Initial Details bundle). As explained above, these actions were not always addressed as they should have been at the time.

42 An action plan was developed by EPUT and overseen by the HSE Steering Group to address issues that had arisen during the proceedings. A paper was submitted to the Executive Safety and Oversight Group on 19 January 2021 from the HSE Steering Group to provide an update on the HSE action plan and to request this was closed, with the progress updates regarding the dormitory programme, the last remaining action, to be provided by the Capital Projects Group moving forward **(Exhibit PS-013: PHSO and HSE Steering Group Closing Report - Jan 21.doc)**. The final copy of the action plan, confirming progress made on the actions was provided alongside the report to the Executive Safety and Oversight which had overall responsibility for overseeing the safety strategy and ensuring oversight was given to action improvements in response to the prosecution **(Exhibit PS-014: HSE Response Action Plan).**

43 As part of the 2020 prosecution, EPUT explained in detail the range of actions and processes in place in NEP prior to the merger and subsequently the actions and processes undertaken by EPUT post-merger in April 2017, to assure the Court that EPUT was taking the matter extremely seriously and had implemented a number of actions to address the concerns raised.

44 Immediately post-merger, EPUT had begun a dedicated programme of analysis and assessment of ligature risk, taking into account the concerns that had been raised particular by the CQC and also the concerns identified during the period of indictment for the 2020 prosecution. Details of actions undertaken are set out at page 2-49 of **(Exhibit PS-011: EPUT Defendant Mitigation Bundle)**, some of which is also included in the HSE action plan, however I set out a high level summary of some of the key developments outlined as part of the HSE proceedings and made by EPUT below. I note that this is not a complete or definitive list of actions undertaken by EPUT to date, but rather, is a summary of the actions that had been taken by the time of the sentencing hearing and were identified in material provided to the Court as part of the HSE proceedings.

a) Ligature safety works: a ligature re-audit (inspection) was requested by the CEO at the point of merger, of all acute, secure and specialist mental health in-patient services across EPUT, which was completed in parallel to the routine/regular ligature inspections already in place. This review identified that the ligature inspection process that had been in place needed strengthening. Wards were reviewed, priority safety improvement works identified and funding released to undertaken recommendations. An ongoing programme was developed, maintained and monitored by the Estates “Task and Finish” Group (i.e.; a group formed to oversee identified tasks through to

completion) and an Expert Estates Reference Group (EERG). The programmes were shared with ward managers, so that they were able to demonstrate progress made and have an understanding of future plans to best mitigate their own risk areas. EPUT invested substantial sums in respect of the environmental ligature work programme.

b) Ligature audits sign off group: in November 2018 there was a review of the Ligature Audit Sign Off Group, a group that had been in place since 2014 in the SEPT and had continued to meet on a quarterly basis since merger. The group's terms of reference were reviewed, the name changed to become the Ligature Risk Reduction Group (LRRG) and the frequency changed, to monthly meetings. The group was a sub-committee of the Health Safety and Security Committee ("HSSC"). It aimed to ensure that ligature risk assessment inspections were effective with appropriate control measures in place; that regulatory and legislative requirements and Safety Alerts were addressed; that risks were identified and managed as required; and to ensure there were appropriate and effective assurance and governance structures.

c) Alerts and Datix system: a process was implemented to record all alerts received (e.g. Medical Device Alerts, NHS Estates Alerts, Field Safety Notices, Department of Health Alerts) on to Datix and to be cascaded to the relevant leads who are required to action as appropriate.

d) Capital and revenue investment and risk stratification: EPUT moved to an approach based on risk stratification, to prioritise capital and revenue investment for a more dynamic process, influenced by risk and experience/history.

e) Ligature risk assessments: ligature risk assessments were reviewed by the Risk Management Team with the Estates Team and local clinical leaders with the aim of ensuring that they reflected current risks and that mitigation plans were realistic. A new Ligature Risk Assessment and Management Policy and Procedure was developed and launched in April 2019 to include a working document to confirm the standards for reduced ligature fixture and fittings and the requirement for and function of the red tabbed wallets, introduced in 2018. Ligature risk assessments were conducted every year on every ward. In September 2020, the Ligature Risk Assessment Tool was again reviewed and updated, to ensure safety alerts received were considered as part the inspection. Safety alerts received were discussed at the HSSC and Operational Managers are tasked with cascading this information to their teams, who are then expected to ensure their heat maps are updated. All alerts are now mapped onto the Ligature Risk Assessment Tool.

f) Audits: actions required following a ligature risk assessment were recorded on the Datix actions module, which is monitored by the Risk Management Team. Overdue actions were reported to the LRRG/HSSC on a monthly basis.

g) Red Tabbed Ligature Wallet: introduced so that each mental health ward had an A3 Red Tabbed Ligature Wallet, which was kept in the ward office and all staff were made aware of its requirements and contents. This included: ligature cutters; a copy of the most recent Ward Ligature Inspection Report; a laminated copy of the 'Emergency Procedure – use of ligature cutters; laminated photos of risk areas; procurement and maintenance of ligature cutters information sheet; a sign in sheet; a ligature cutter poster and a heat map. As part of an induction to the ward, staff should have reviewed the wallet, including the heat map and ligature photos.

h) Windows – substantial investment in new windows/fittings. Where windows were identified by risk assessments as requiring replacement, these were replaced with 'Polar' windows, which are recognised as appropriate for inpatient psychiatric ward. Pending replacement, interim steps were taken to deal with ligature risks on windows.

i) Work was undertaken to replace shower rails and bedroom and bathroom curtain rails.

j) Risk management arrangements: set out in the Risk Management and Assurance Framework which was reviewed annually. The Board Assurance Framework (BAF) identifies potential risks. Action plans were in place or developed to mitigate potential risks recorded on the BAF. Each action plan was assigned to a standing Committee of the Board and reviewed quarterly, to ensure that action was taken as appropriate. The BAF was considered by the Board of Directors at each meeting (ten times each year). The Corporate Risk Register (CRR) was reviewed quarterly by the Board of Directors. Directorate Risk Registers (DRR) were in place to capture service-specific risks. Risks were escalated and downgraded to and from the BAF, CRR and DRR. At every meeting within the governance structure, agendas provided for identification and escalation of potential risks (or hotspots). The risk management arrangements were subject to oversight by the Audit Committee and an annual independent audit.

k) All incidents reported were triaged by the Risk Management Team, to ensure any significant incidents were correctly reported and therefore followed up appropriately. All incidents rated as having moderate harm (or greater) were subjected to review by the Moderate Harms Group, to ensure that the appropriate level of investigation was carried out. All incidents meeting the NHSI Serious Incident reporting threshold were subject to detailed independent investigation.

l) Significant investment in ligature and safety spend and patient safety spend.

m) Governance – EPUT had put in place extensive measures to strengthen effective leadership and the management structure including the appointment of a Director of Safety whose role is to support the effective implementation of the 'Safety First, Safety Always' Strategy. The Executive Safety Oversight Group ('ESOG') was implemented effective from November 2020, its Terms of Reference were to oversee the development, curation and delivery of a Trust wide safety strategy, encompassing (but not limited to):

- Physical environment
- Staffing and management Structures
- Leadership and culture
- Record Keeping

and to consolidate and oversee the development and delivery of action plans relating to:

- CQC Reports
- HSE reports
- PHSO reports
- Any other expert or external review recommendations

ensuring EPUT had addressed the themes coming out of the prosecution.

Impact on the Trust of the proceedings

45 As set out in the finance statement provided [I/S] as part of EPUT's mitigation bundle for the sentencing hearing, EPUT would be (and has subsequently been) significantly impacted by the fine.

46 No additional funds were available to cover the cost of the fine. In essence, the fine was paid for by the usual income streams from EPUT's commissioners. This has a particular impact due to EPUT's current financial position and has meant a reduction in funds available for front line services and the ability of EPUT to plan long term capital projects, service improvement and the significant backlog of planned preventative maintenance. This will continue for the next couple of years whilst the remaining instalments are paid.

Civil claims

47 EPUT has reviewed all the available records (both electronic and paper files) to identify all civil claims received by EPUT and the predecessor organisations, during the Relevant Period **(Exhibit PS-015: Civil claims spreadsheet).** To the best of EPUT's knowledge and belief all relevant civil claims have been included.

Statement of Truth

The content of this statement is true to the best of my knowledge and belief.

Signed [I/S]

Dated 20.03.25