CTI Paper prepared for Baroness Lampard, Inquiry Chair, in relation to

LIGATURE INCIDENT DATA

SUMMARY

1. This paper seeks to summarise the witness statements of EPUT, NELFT, The Priory Group ('Priory'), Cygnet Healthcare and St Andrew's Healthcare (collectively hereafter referred to as 'the Providers') in relation to ligature incident data.

2. The Inquiry asked the Providers to provide various information in respect of ligature incidents in Essex between 1 January 2000 and 31 December 2023 ('the relevant period'). In particular, the Providers were asked to populate a template provided by the Inquiry, with data relating to ligature incidents.

3. The purpose of obtaining such information at this stage was to enable the Inquiry to investigate what was happening within the Providers in relation to ligature incidents during the relevant period, and to inform any further lines of investigation and disclosure that the Inquiry might wish to seek. Potential further lines of investigation arising from the material provided are set out at the end of this paper.

4. Not all of the Providers have responded in time, or indeed at all:
    a. EPUT has provided a witness statement and 37 exhibits.
    b. Priory has provided a witness statement and 2 exhibits

c. NELFT, Cygnet Healthcare and St Andrew's Healthcare have not responded in time for their material to be considered within this paper.

5. The Inquiry recognises that there are too many limitations to the data so far provided by EPUT and Priory (not least because both are continuing to search for relevant data), to enable any reliable conclusions. However, where possible this paper has attempted to suggest further lines of investigation for the Inquiry to consider.

INTRODUCTION

6. As set out in the Inquiry's Terms of Reference, the Inquiry is investigating circumstances surrounding the deaths of mental health inpatients under the care of NHS Trusts in Essex between 1 January 2000 and 31 December 2023.

7. Through analysis of the information provided to the Inquiry by January 2025, ligature-related deaths and serious incidents relating to the use of ligature points, have emerged as a recurring issue.

8. In order to meet its Terms of Reference and understand the significance of this issue, the Inquiry requested information concerning ligature-related deaths and serious incidents via Rule 9 requests for evidence (and follow up Rule 9 requests) to EPUT (and its predecessor organisations, NEPT and SEPT), NELFT, Priory, Cygnet Healthcare and St Andrew's Healthcare.

9. For the purposes of this Rule 9 request for evidence in relation to ligature incidents, the Inquiry considers that a 'serious incident' refers to:
   a. A 'near miss' i.e. an incident, act or omission in care that had the potential to result in harm, but did not, primarily due to chance or interception.
   b. Any case that did not result in death, but the individual came to some level of harm.
   c. Any case that did not result in death but was later the subject of a Serious Incident Report, Root-Cause Analysis, and/or Patient Safety Incident Response investigation.
   d. Any case that did not result in death but was later the subject of any other similar internal or external investigation.

10. The Providers were asked to provide the following ligature incident data for the relevant period:
    a. The number of ligature incidents per facility per year that resulted in a death.

b. The number of ligature incidents per facility per year that resulted in some level of harm short of death.
c. The number of ligature incidents per facility per year that would be classified as a 'near miss'.
d. The number of ligature incidents per facility per year that did not result in death, but were the subject of a Serious Incident Report, Root-Cause Analysis, and/or Patient Safety Incident Response investigation (or any other similar internal investigation), as described above.
e. The number of ligature incidents per facility per year that did not result in death but were the subject of any external investigation. Including, but not limited to, investigations and reviews of complaints conducted by bodies such as:
    i. The Care Quality Commission ('CQC');
    ii. The Health and Safety Executive ('HSE');
    iii. The Health Services Safety Investigations Body ('HSSIB')
    iv. The Parliamentary and Health Service Ombudsman ('PHSO')
f. An outline of any lessons learned from any internal or external investigations, and how these lessons were identified, documented, and communicated to staff, leadership, or other stakeholders. The Inquiry requested a summary of any action taken in response to any investigations, including any measures introduced to address identified issues and prevent similar incidents from recurring. This was to cover any procedural changes, improvements in training or supervision, and modifications to risk management processes. Additionally, how these lessons were communicated across the Trust, and any actions taken to ensure their implementation.
g. A summary of any outcomes that transpired following any action taken by the Trust in response to any investigations.
h. In relation to the Providers' annual programme of audit and annual risk assessment audits:
    i. How many high-level ligature points were identified per facility per year?

ii. How many potential ligature points were identified per facility per year?

iii. What action was taken following the identification of any high-level or potential ligature points, by whom, and were any changes made to audit methodology or reporting practices during the relevant period? If so, what are the details and reason for these changes.

i. A summary of what information and/or training is available to staff regarding the identification, prevention and response to ligature risks, including who provides the training and how often.

j. A comprehensive list of any material or documentation that is used by the Trust to record and/or monitor ligature data, including (but not limited to) internal policies, protocols and risk assessment tools.

11. The Inquiry was seeking to obtain essential data in relation to ligature related incidents over the relevant period. The Inquiry was also looking for an overview of any internal and external investigations that followed such incidents, audit and training information, and any actions arising from any such investigations and audits.

12. The Providers have responded in varying levels of detail to the Rule 9 requests for evidence sent by the Inquiry. This paper will replicate and summarise the key points within the Rule 9 witness statement responses as well as highlighting some omissions and limitations identified within those responses.

13. If there are errors within the information that has been provided by the Providers, including within witness statements, those errors will necessarily be replicated within this paper and accompanying presentation. For example, the Inquiry notes that inconsistent dates have been provided for reliance on Datix, the online system used by the Providers to record any incidents and risks. The fact that this information has been replicated or

summarised below does not mean that the Inquiry accepts that it is accurate in all regards.

14. The purpose of this paper and accompanying presentation is not to test the evidence. The time for challenging the evidence provided as part of these contextual hearings will be at a later stage.

15. At the outset, the Inquiry would like to make clear that there are evidently limitations and omissions within the ligature incident data that has been provided by all Providers. Before coming to any conclusions that are to be relied upon in the final report, the Inquiry will work with its Independent Assessors and Experts, including the Inquiry's Expert Statistician, Professor Donnelly, to identify any deficiencies within the data provided and ensure that it is as complete and therefore reliable as possible. The Inquiry will further work with its Independent Assessors and Experts to ensure that any final conclusions reached in respect of the data provided are reasonable and appropriately evidence- based.

16. This paper was completed by **27 March 2025**, to allow sufficient time for disclosure to Core Participants ahead of the April hearing. As such, any material that was received on or after this date has not formed part of this paper or accompanying presentation. However, all such relevant material will be considered by the Inquiry, and will feed into investigations to fulfil the Terms of Reference.

17. The Inquiry has received numerous exhibits from the Providers that will not be disclosed at this time, as whilst they are largely of relevance to the Inquiry's investigations, the Inquiry does not consider the documents pertinent to the issues to be considered in the April hearing, and takes the view that it is not necessary or proportionate to disclose them at this stage.

EPUT

18. Rule 9(8) was sent to EPUT on 9 January 2025, with a deadline for response of 11 February 2025.

19. EPUT provided the witness statement of Ann Sheridan dated 25 March 2025 in response to the Rule 9 request. This is a 30-page statement, with 37 accompanying exhibits.

Limitations to the Data

20. By way of letter dated 17 January 2025, EPUT advised the Inquiry that searches are ongoing in respect of records pre-dating the implementation of Datix (April 2011 for SEPT and March 2013 for NEPT). However, EPUT anticipate that there may be gaps in the data due to the length of time that has passed and changes in personnel and subsequent loss of "corporate memory." The Inquiry finds this concerning, and may consider further the impact of loss of "corporate memory".

21. Limitations to the data collection and analysis that have been identified by EPUT in the witness statement are:

    1. There were five weeks to provide the information requested, which EPUT consider was limited time.

    2. EPUT state that they have collected incident data from a variety of sources, but for the most part searches in relation to incidents pre-dating 2010 are ongoing and an update is expected in June 2025:

        a. Information in relation to archive boxes containing paper incident forms for SEPT and NEPT covering incidents between 2000 and 2010 will be provided in June 2025 following completion of manual searches.

b. Information in relation to SEPT's Ulysses (Risk Management System) covering incidents from September 2000 to March 2011 will be provided in June 2025 following completion of manual searches.

c. Information in relation to NEPT's Respond Database (Risk Management System) covering incidents from January 2002 to September 2015 and complaints from August 2000 to October 2015 will be provided by 2 June 2025 following completion of manual searches.

d. SEPT's Datix System covers incidents from April 2010 to April 2017.

e. NEPT's Datix system covers incidents from April 2009 to April 2017.

f. EPUT's Datix system covers incidents from April 2017 to present.

3. EPUT confirm that there is an overlap in the usage of some of the systems. There was a phased rollout of Datix across the Trusts, meaning that some paper forms were still being produced at some locations after the initial introduction of Datix. Until further reviews are completed by EPUT, they cannot confirm whether there were any incidents at NEPT since June 2009 and SEPT since April 2010 that would have been recorded only on paper, Respond or Ulysses (without an incident also being raised on Datix).

4. EPUT highlight that the level of harm associated with an incident reported on Datix is up to the interpretation of the person reporting the incident and there is no easy way to validate the level of harm that the reporter assigned. It is notable that this is something that the Inquiry's Expert, Dr Davidson, recognises at Paragraph 7.2 of his report[1], whereby

[1] Dr Ian Davidson, Expert Report (18/03/25): An overview of good care and minimum standards of delivery of care in mental health inpatients, Paragraph 7.2

he states that for 'low and zero harm' incidents there is a high degree of subjectiveness as to what needs reporting.

5. EPUT state that where the Datix system identified incidents that were subject to a Serious Incident or Patient Safety Incident Investigation, manual searches were then conducted to locate the report. In some cases, the report could not be located, this has been marked as 'report not found.' EPUT will continue to search for these reports and an update will be provided in June 2025.

6. To find complaints to the CQC that pre-date the introduction of Datix, EPUT are reviewing archive boxes. They expect to be able to provide the outcome of this work in June 2025.

7. EPUT's further searches in respect of investigations by the Health Services Safety Investigations Body (HSSIB) will be completed by June 2025 and an update will be provided if additional information is found.

8. EPUT need to undertake manual reviews to document actions from before the adoption of Datix for SEPT ligature audits, by June 2025.

9. EPUT has been unable to locate a database with actions from NEPT ligature inspections. They believe that the actions would have only been recorded on each inspection's individual template. A manual review of all NEPT files will need to be conducted by EPUT to list out the actions from NEPT audits (to be completed by June 2025).

10. EPUT state that they will use best endeavours to populate the audit columns of the template provided by the Inquiry, and to complete the audit tab by June 2025. In the meantime, they state that they have exhibited the raw audit data extracted from Datix. EPUT state that they

need to conduct further manual reviews to look for pre-Datix audit data (to be provided in June 2025).

11. EPUT state that they will populate column M in relation to improvement work by June 2025. They further state that this will include detailed actions from ligature audits, changes to policies/process and environmental improvements.

12. EPUT state that there will be ligature training delivered on the job that isn't captured in the witness statement. They also state that it has not been possible to break down the training delivered by ward and attendance rate. EPUT state that it would be possible to provide the current training compliance by team, but providing past data would require cross referencing employee training data against employment details to identify the ward the person was working on at the time they completed the training.

EPUT – Approach to Data Collection

22. EPUT state that incident data was collected from 6 sources, including paper archive boxes (albeit searches in relation to 3 of those sources remains ongoing, as above). The electronic sources were searched using specific relevant search criteria.

23. EPUT have identified that the 'Ligature' sub-category had only been in use on SEPT's Datix form since 02/03/2011 and the 'Ligature involved' code on NEPT's Datix form since 16/03/2013. To address this issue, EPUT state that they then extracted all incidents from these databases between their implementation date and the date that the ligature sub-categories were introduced. This resulted in 10,779 incidents for SEPT and 17,751 incidents for NEPT that EPUT then searched using key word searches. This resulted in 1035 flagged incidents to be reviewed from SEPT and 2447 from NEPT. A manual

review of all flagged incidents was then undertaken by EPUT to determine whether the incident was a ligature and was within scope.

24. EPUT has taken a ligature incident to be any incident that involved material that was used or could have been used to bind or tie a person's neck. They have excluded instances where pressure to the neck was applied using the patient's or another patient's hands. They state that a ligature may involve the use of a fixed point, but often this is not the case.

25. EPUT have included all ligature incidents in their response, and state that this could be further refined into those using a fixed ligature point, and those that did not. Although the Inquiry did not ask Providers to distinguish between fixed and non-fixed ligature points within the Rule 9 request, this will be considered during further investigations and the Inquiry may ask the Providers to make this distinction.

26. Where the Datix system indicated that the degree of harm was 'death,' then EPUT state that the incident has been recorded on the template provided by the Inquiry [Exhibit AG-001] as a death.

27. Where the Datix system indicated that the degree of harm was 'Low', 'Minor', 'Moderate' or 'Severe' then EPUT state that the incident has been recorded on the template as an incident resulting in harm.

28. EPUT have used the Inquiry's definition of a 'near miss' incident (i.e. where no harm is caused), and expressly state that this could also include incidents where material that could potentially have been used by a patient to ligature was found, but a ligature had not yet occurred. Therefore, where the Datix system indicated that the degree of harm was 'no harm', EPUT have recorded the incident on the template as a 'near miss.'

29. EPUT have recorded a repeat attempt where there has been a repeat attempt by a person on the same ward in the same year.

30. EPUT state that the Datix system indicates whether an incident is subject to a Serious Incident or Patient Safety Incident Investigation. They state that they have undertaken manual searches to locate the report from the investigation and if the report could not be located EPUT has indicated this on the template.

31. It is evident to the Inquiry that there is data missing from the template completed by EPUT containing their ligature incident related data [Exhibit AS02-01]. For example, there is no data for various years in relation to the Crystal Centre, or Landermere Centre or St Margaret's. These are just a few examples of the data that is evidently missing at present. The Inquiry awaits further disclosure from EPUT and will seek to ensure that the data provided is as complete as possible to ensure meaningful analysis.

EPUT – External Investigations and Learning Related to Ligature Incidents not Resulting in Death

CQC

32. EPUT believes that there have been no investigations carried out by the CQC due to ligature incidents that did not result in death.

33. However, EPUT have identified three CQC inspections where concerns were received about the environment, but not necessarily in relation to ligature risk. EPUT confirm that the majority of CQC inspections did make recommendations for improvements around ligature, with later inspections acknowledging the reduced numbers of ligature points and focussing more on refinements to ligature safety (e.g. ensuring appropriate cutters are in the ligature response wallet). This may be something that the Inquiry wishes to investigate further.

34. EPUT have identified that 11 complaints were raised to them by the CQC within the relevant period (identified by searching Datix for complaints linked to the CQC). This data has been provided by EPUT within [Exhibit AS02-02: CQC and PHSO Complaints Data].

HSE

35. EPUT state that they have undertaken a review of all known cases reported to HSE involving ligature incidents that did not result in death.

36. They have identified a case on Ardleigh Ward in April 2013 that was included in a HSE investigation and subsequent prosecution of the Trust related to ligature incidents and deaths. The report found that the collapsible shower rail that the ligature had been tied to didn't collapse as it was designed to. EPUT state that this led to an audit across the Trust to understand the problem better and ensure that all rails had been checked within two weeks of the incident.

37. This paper will not go into further details of the HSE investigation and subsequent prosecution of the EPUT. However, it is noted that EPUT have exhibited various documents in relation to this investigation, and the Inquiry will continue to analyse material provided by EPUT and investigate further, where necessary and appropriate [Exhibits AS02-03 – 08].

38. From 2019 onwards, EPUT state that they have made substantial investment into new windows/fittings with the aim of reducing ligature risk and absconsion risk.

HSSIB

39. EPUT state that they have reviewed their internal drives for investigations by the HSSIB, but no relevant documents have been located in relation to ligature incidents to date.

Parliamentary and Health Service Ombudsman (PHSO)

40. EPUT state that they have manually reviewed all PHSO complaints identified on Datix and any that made reference to a form of ligature were highlighted. They have identified three incidents that resulted in investigation by the PHSO. This information has been provided within [Exhibit AS02-02: CQC and PHSO Complaints Data].

East London Foundation Trust Peer Review

41. While not an external investigation directly related to an incident not resulting in harm, EPUT state that they did engage with ELFT to conduct a peer review of ligature safety on EPUT wards. EPUT state that this review concluded that they had a clear ligature process in place to manage environmental risks of ligature. They confirm that there were recommendations for improvement in governance and working practice, environment, workforce, and training and learning. These have been provided within [Exhibit AS02-09: ELFT Peer Review Report].

42. EPUT state that they completed the resulting action plan to address the recommendations, which has been provided at [Exhibit AS02-10: ELFT Action Plan]. The Inquiry notes that this appears to show that all actions were completed/closed by August 2022, from site visits undertaken in May 2021.

EPUT Annual Programme of Audits and Annual Risk Assessment Audits: Current Practice

43. It appears that in their witness statement EPUT have addressed current practice in relation to the annual programme of ligature inspections and measures in place to reduce ligature risks. The Inquiry may wish to seek further information in relation to practices that were in place over the relevant period, and any changes that occurred during that time.

44. EPUT state that ligature inspections are undertaken on an annual basis alongside a number of measures in place to support the management of ligature in the Trust to identify, assess and manage ligature environmental risks and are completed to support the reduction of ligature risk.

45. EPUT have listed other measures that aim to reduce ligature risk, and provided documentation in relation to some of those measures:
    a. Ligature Wallets
    b. Suicide Prevention Clinical Guideline [Exhibit AS02-11]
    c. Datix (safety alerts and shared learning)
    d. Ward manager actions
    e. Trust Estates Ligature Works Program
    f. Estates annual testing program
    g. Ligature Risk Reduction Group (LRRG)

46. EPUT state that various measures are in place to facilitate annual ligature audits:

    a. The Health and Safety and Violence Prevention & Reduction teams ('VAPR') facilitate the annual environmental ligature risk inspection programme.

    b. The Inspection Team are jointly responsible for completing an inspection using the inspection tool which audits against the agreed environmental standards [Exhibit AS02-12: EPUT Fixture Fittings Ligature Environmental & Garden Standards] and that this has been developed using a range of national guidance and internal learning.

    c. The Inspection Team meet at the ward and undertake the inspection jointly visually assessing each room against the inspection tool and recording breaches in standard/maintenance issues and any mitigations.

d. Following each annual inspection the Health & Safety and VAPR representative will discuss and feedback any high-risk actions with the ward manager (prior to leaving the ward) and the Estates representative will upload all tasks onto the Trust's system. The full final report is issued within 15 working days of the inspection. Ward Managers, Senior Managers and Matrons are responsible for ensuring all actions identified at a ligature inspection are completed within timescales and that mitigations are in place until actions are completed.

e. In addition to the annual inspections all wards have a follow up support review visit (6 months after annual inspection).

f. There were some adjustments to the ligature inspection process during the COVID period. In short, in person inspections were paused from 26 March until 18 August 2020. EPUT have provided [Exhibit AS02-13: Ligature Environmental Risk Assessment and Management Policy].

EPUT inspection data

47. EPUT state that the EPUT Ligature Actions listing report [Exhibit AS02-14: EPUT Ligature Actions Listing] contains information extracted from the EPUT Datix database, of any action recorded that resulted from a Ligature inspection from 01/04/2017 to December 2023.

SEPT inspection data

48. EPUT state that the SEPT Ligature Actions listing report [Exhibit AS02-15: SEPT Ligature Actions Listing] contains information extracted from the legacy SEPT Datix RichClient database, of any action recorded that resulted from a Ligature inspection within the Risk module. The earliest record on this system dates to July 2014 and runs until the merger in 2017. They confirm

that manual reviews are required to document actions before the adoption of SEPT's Datix system in February 2015.

NEPT Inspection Data

49. EPUT have provided the NEPT Ligature Actions listing report [Exhibit AS02-16: NEPT Ligature Actions Listing] however they have been unable to locate a database with actions from NEPT ligature inspection. EPUT are therefore undertaking a manual review to list out the actions from NEPT audits (to be completed by June 2025).

Continuous Monitoring of Environmental Risks: Current EPUT Systems

50. It appears that in their witness statement EPUT have addressed current systems that are in place to monitor environmental risks. The Inquiry may wish to seek further information in relation to systems that were in place over the relevant period, and any changes that occurred during that time.

51. EPUT state that ward staff are responsible for monitoring environmental risk on a daily basis and that a 'Security Nurse' is allocated on each shift to ensure oversight of ward-based security matters and environmental checks.

52. They confirm that where potential environmental risks are identified, these are escalated to the shift lead/ward manager and Estates (if required). The Trust holds twice daily 'Safety Huddles' where patient safety incidents are reviewed and EPUT has invested in patient safety experts that will support oversight of all incidents that is then discussed at a weekly senior clinical huddle with the senior leadership team. Ad hoc visits are conducted by people from the Trust's ICBs and Local Authorities, as well as by patient partners, Executive Directors and members of the Trust Board.

EPUT Ligature Training

53. EPUT confirm that the requirement for ligature related training is set out both in the Ligature Environmental Risk Policy [Exhibits AS02-13: CP75 – Ligature Environmental Risk Assessment and Management Policy] and the Trust Mandatory Training Policy [Exhibit AS02-17: HR21 – Induction and Mandatory Training Policy]. In addition, they state that there is a range of information provided to staff.

54. EPUT have provided several documents in relation to information that is currently provided to staff regarding ligature awareness:
    a. Exhibit AS02-18: Local Induction Checklist Signage Sheet
    b. Exhibit AS02-19: Safe Suspension of Curtains
    c. Exhibit AS02-20: Contents of Red Tabbed Wallet
    d. Exhibit AS02-21: Procurement Storage Maintenance of Ligature Cutters
    e. Exhibit AS02-22: Ligature Cutters Station A4 Poster
    f. Exhibit AS02-23: Emergency Procedure A4 Poster

55. EPUT have provided a summary of currently available training content:
    a. Preventing Suicide by Ligature: online training provided by EPUT for all staff working in an inpatient setting (or if it is required as part of their role).
    b. Ligature Awareness Training: mandatory classroom-based training for all staff working in an inpatient setting (or if it is required as part of their role).
    c. Ligature Environmental Risk Assessment Training: online training provided by TIDAL Training Ltd for all staff who undertake ligature inspections as part of ligature inspection programme.
    d. Corporate Induction: online training provided by EPUT for all new staff, including a basic introduction to ligature environmental risks.

56. EPUT has completed the 'Training and Documentation' tab of the template provided by the Inquiry [Exhibit AS02-01]. This provides information in relation to training that was provided Trust wide from 2009 through to the present day.

57. The Inquiry may wish to seek further information in relation to training practices and programmes that were in place during the relevant period, as EPUT have so far provided information in relation to current ligature related training.

EPUT Material and/or Documents Used to Record and/or Monitor Ligature Data

58. Within their witness statement, EPUT has provided a table outlining the key materials and documentation used by the Trust to aid and record the monitoring of ligatures, and associated exhibits. This includes:
    a. Exhibit AS02-24: Standard Operating Procedure
    b. Exhibit AS02-25: Ligature Inspection Tool (v22.1)
    c. Exhibit AS02-26: Support Visits Tool
    d. Exhibit AS02-27: Ligature Policy at a Glance
    e. Exhibit AS02-28: Adverse Incident Policy
    f. Exhibit AS02-29: Witness Report
    g. Exhibit AS02-30: 3 Day Follow up RIDDOR Incident Report (Service User Affected)
    h. Exhibit AS02-31: 3 Day Follow up RIDDOR Incident Report (Staff Affected)
    i. Exhibit AS02-32: Inpatient (Mental Health) management following the unexpected death of a patient
    j. Exhibit AS02-33: Community Mental Health Management following the unexpected death of a patient
    k. Exhibit AS02-34: Clinical Risk Assessment and Safety Management Policy
    l. Exhibit AS02-35: Ligature Inspection Summary
    m. Exhibit AS02-36: Ligature Risk Report
    n. Exhibit AS02-37: Ligature Governance Structure

59. It appears that these are current materials and documentation used by EPUT to aid the recording and monitoring of ligatures. The Inquiry may wish to seek further information and documentation in relation to materials that were used throughout the relevant period.

EPUT's Response to Rule 9(8)

60. The Inquiry considers that there is data missing in respect of certain facilities and wards over the relevant period. Once there has been full disclosure the Inquiry will seek to fill any evidential gaps or ascertain why it has not been possible to provide such data.

61. Ultimately, further disclosure is expected in June 2025 to fully respond to the matters raised by the Inquiry in Rule 9(8). The Inquiry will consider this disclosure upon receipt, and ensure that it is satisfied that EPUT have fully responded to Rule 9(8) by providing all information and documentation requested therein.

NELFT

62. Rule 9(4) was sent to NELFT on 28 January 2025, with a deadline of 25 February 2025.

The Priory Group

63. Rule 9(4) was sent to Priory on 28 January 2025 with a deadline of 25 February 2025.

64. Priory have provided a signed witness statement in response to the Rule 9 request, from Gary Stobbs, Managing Director for the East region of health care within Priory, dated 21 March 2025. This is a 9-page witness statement with 2 exhibits.

Priory - Limitations to the Data

65. Limitations to the data collection and analysis that have been identified in the witness statement by Priory are:

1. Priory merged with Partnerships in Care ('PiC') in 2016 and there are limited records available to review in respect of the PiC sites prior to that date, but enquiries remain ongoing in relation to paper-based archives. Following a strategic review, Oaktree Manor ceased operations and closed in September 2019.

2. Priory state that they have found populating the template provided by the Inquiry for audits to be extremely challenging and time consuming. Priory state that a manual review of each individual audit template and an analysis of each audit is required in order to complete the template. Priory have not achieved this within the original timeframe. Priory given the example of Suttons Manor, whereby each year there are at least 60 separate audits.

3. Searches are continuing by Priory to establish if any historic paper audits for the relevant period can be located.

4. Priory are continuing to search hard copy archives.

5. With regards to Oaktree Manor, Priory state that it is currently not possible to confirm the amount of 'high level' ligature points or how many ligature points were identified prior to its closure in 2019 due to a lack of available information but Priory will make further enquiries in this regard.

6. With regards to training, Priory state that it has proven difficult to complete the template. Priory are continuing to search hard copies and electronic drives.

Priory – Approach to Data Collection

66. Priory state that the data provided relates to mental health facilities owned by Priory (which includes certain services which were formerly owned and operated by PiC until they transferred to Priory in November 2016).

67. Priory confirm that prior to 2012 both PiC and Priory operated a paper-based incident reporting system utilising 'IR1' forms.

68. In respect of electronic data, Priory state that relevant data has been retrieved from three incident reporting systems:
    a. Datix
    b. E-compliance (used by Priory between 2012-2019) and
    c. IRIS (used by PiC sites between 2012 – August 2019).

    They confirm that the incident grading categories are broadly similar and are based on the level of harm or injury actually sustained by the patient or service user.

69. Priory confirm that they have recorded 'near misses' on the template provided by the Inquiry where they are reported as such and also included where an incident is reported as 'no harm.'

70. Priory state that ligature incidents are reported via the use of the incident reporting systems, currently Datix. They state that they are initially subject to a local investigation on site by the clinical and management team, and findings from this review are discussed as part of Ward Rounds with the Clinical Team (for lower risk incidents) or referred upwards via the 24-hour notification system (for higher risk incidents).

71. Priory assert that depending on the seriousness of the incident, in addition to a Datix entry, a 24-hour report is also prepared by the Hospital Director,

Director of Clinical Services or Ward Manager, which contains a 'further action required' section. The criteria for upwards reporting are set out in the Priory incident management and reporting policy.

72. Priory state that a further 72-hour fact finding report (providing more detailed information about the incident) should be prepared and a Team Incident Review ('TIR') report, containing recommendations for actions to be taken by the relevant site, may be completed depending on the seriousness of the incident. Priory further state that 72-hour reports are reviewed weekly during a call chaired by the Director of Quality and a decision is made at a regional level as to whether a TIR is required, or if a substantive investigation is needed.

73. Priory state that where areas for improvement are identified from a TIR (or substantive investigations), an action plan will be drafted by the site, including timescales, responsibilities and review dates.

74. The Inquiry is aware that this data is not complete as searches of hard copy archives are ongoing and the Inquiry notes that there are omissions in the data that has been provided so far in relation to ligature incidents [Exhibit GS01]. For example, data has only been provided for Elm Park ward for 2016, 2021 and 2023. The Inquiry awaits further disclosure and, as with EPUT, will seek to fill any gaps within the data provided by Priory to ensure meaningful and reliable analysis.

75. Where repeat attempts have been documented, Priory state that in most cases these have resulted in no or low harm, where staff have intervened in a timely manner and no medical attention has been required.

76. Priory have set out in the witness statement the general regulatory oversight in relation to serious incidents.

77. Priory state that during the relevant period, ligature risk management at the Essex sites developed as learning was disseminated from a number of sources including:
    a. Developments in National Guidance
    b. Stakeholder feedback
    c. Learning lessons from incidents at other sites which was disseminated across all Priory hospitals

Priory Annual Programme of Audit and Annual Risk Assessment Audits

78. Priory state that they do not delineate between 'high level' and 'low level' ligature points. However, they state that their data does record the number of high-risk ligature points based on a scoring system, and so that has been used to populate the template.

79. Priory assert that they have audits for Chelmsford, Suttons Manor and Elm Park for 2017-2023 and the ligature audit process requires audits to be completed for every area of a Hospital (internal and external areas where patients have access). The Inquiry has granted Priory an extension to undertake a manual review of each individual audit template and an analysis of each audit.

80. With regards to audits at Oaktree Manor, Priory state that enquiries are ongoing.

Priory Information and/or Training in Relation to Ligature Risks

81. In relation to information regarding ligature risk training, Priory state that searches of hard copy and electronic drives are ongoing.

82. However, within their witness statement Priory assert that current practice as follows:

a. Training specific to ligature management is covered in Immediate Life Support (ILS) for qualified nursing and medical staff which is completed annually.

b. All nursing staff receive mandatory training in the management of suicide and self-harm as part of their induction to all sites. Prevention of suicide webinars are available and accessible to all staff and are available for all to access at any time on the Priory Intranet.

c. All staff receive supernumerary days on the wards before being allowed to be included in the staffing complement for each shift. This includes orientation to the ward which includes awareness of ligature heat maps, and where ligature cutters are stored.

d. Since March 2023, all staff who are required to undertake ligature audits are required to complete webinar training hosted by either an Associate Director of Quality and/or Quality Improvement Lead to ensure they are competent to complete the role. Audits are always completed by 2 staff – one senior clinician and one senior non-clinician as per policy.

e. Whilst in the first 12 weeks of position, nursing staff are required to complete ILS training and HCA staff Basic Life Support (BLS) training, including the management of non-responsive persons and familiarisation with ligature cutters. This is refreshed annually.

f. As per Priory's Clinical Governance policy all sites are required to complete training drills for varying scenarios over a 12-month period. This includes medical drills and ligature scenarios.

83. [Exhibit GS01] is the template that the Inquiry asked Priory to complete, containing the ligature incident data. This has been partially completed. The Training and Documentation Tab confirms:

a. Immediate Life Support classroom-based annual training by Knights from 2016-2023 at Chelmsford, Suttons Manor and Elm Park.

b. Basic Life Support classroom-based induction and 3 yearly training by Knights from 2016-2023 at Chelmsford, Suttons Manor and Elm Park and 2018-2019 at Oaktree Manor.

84. The Inquiry may wish to seek further information and documentation in relation to ligature training and documentation that was available in the earlier part of the relevant period.

85. Priory state that [Exhibit GS02] contains a list of the materials or documentation used by Priory to record and/or monitor ligature data including internal policies, protocol and risk assessment tools. Priory state that this does not include training materials, internal learning communications and patient feedback as these are not used to monitor the data collected from ligature incidents. The Inquiry may wish to seek disclosure of at least some of this material, for further analysis and investigation.

Has Priory Fully Responded to the Inquiry's Rule 9(4) Request for Evidence?

86. The Inquiry considers that there is data missing in respect of certain facilities and wards over the relevant period. Once there has been full disclosure the Inquiry will seek to fill any evidential gaps or ascertain why it has not been possible to provide such data. An extension has been granted to Priory to provide all of the requested information. Hard copy searches are ongoing and therefore so far there has only been a partial response.

87. The Inquiry will consider further disclosure upon receipt, and ensure that it is satisfied that Priory have fully responded to Rule 9(4) by providing all information and documentation requested therein.

Cygnet Healthcare

114. Rule 9(4) was sent to Cygnet Healthcare on 28 January 2025 with a deadline of 25 February 2025.

115. An extension was agreed of 28 March 2025, and therefore due to time constraints any material received by Cygnet Healthcare has not been considered in preparing this paper and accompanying presentation.

St Andrew's Healthcare

116. Rule 9(4) was sent to St Andrew's Healthcare on 28 January 2025 with a deadline of 25 February 2025.

117. An extension was agreed of 28 March 2025, and therefore due to time constraints any material received by St Andrew's Healthcare has not been considered in preparing this paper and accompanying presentation.

Next Steps

118. The investigation of ligature incidents is a vital piece of work to enable the Inquiry to fulfil its Terms of Reference.

119. The Inquiry awaits significant disclosure from all Providers in relation to the request for ligature incident related data.

120. The Inquiry is considering the data that has been provided and the further data that must be provided. It is taking advice as necessary about this, including from its Expert Health Statistician, Professor Donnelly. The Inquiry is developing lines of investigation consistent with its Terms of Reference and List of Issues. For example, they may include:

a. Were wards fit for purpose?

b. How did decisions in relation to risk and observation levels affect patients? In particular, in relation to individuals who made more than 1 attempt to ligature?

c. What preventative measures were put in place to safeguard patients from harming themselves or others on mental health inpatient wards? In particular:
    a. Have the Providers complied with any ligature audit requirements that were in force during the relevant period?
    b. Were appropriate actions taken in response to ligature incidents (including any internal and external investigations) and/or audits that occurred over the relevant period?

d. Have the Essex Trusts complied with any data recording requirements that were in force during the relevant period? In particular:
    a. Was the data collected adequate, accurate and up to date?
    b. What data was available to the Providers to help them to understand a patient's history?
    c. How was data used to make an informed decision about treatment?
    d. What analysis was undertaken of the data by the Provider?

e. Was appropriate training given to staff at all levels in relation to the prevention of ligature incidents? If not, what other training could or should have been given to staff (whether permanent, temporary or agency staff)?

f. Was there sufficient regulatory oversight of ligature related incidents across the Providers during the relevant period? For example, was sufficient enforcement action taken by regulatory bodies such as the CQC if wards were repeatedly recording a high number of ligature related incidents?

g. Can any meaningful cross-comparison be undertaken across the Providers and/or other data collections? For example, a comparison of the ligature related data as against the wards lists, to provide information as to the average number of incidents per bed per year across the Providers? Or comparison as between the security of the wards and number of ligature related incidents?

h. Can any conclusions be drawn as against the wards that had:
    a. The highest total number of ligature related incidents per year and/or across the relevant period?
    b. The highest number of ligature related deaths per year and/or across the relevant period?
    c. The highest number of ligature related repeat attempts per year and/or across the relevant period?
    d. The highest number of different people making at least 1 attempt to ligature per year and/or across the relevant period?
    e. The highest number of 'near miss' ligature incidents per year and/or across the relevant period?

121. This list is by no means exhaustive. Once the full requested disclosure has been received from the Providers, the Inquiry will seek to fill any evidential gaps or demand a reasonable explanation as to why that has not been possible. Given the importance of this data in helping the Inquiry to understand what was happening within the Providers in relation to ligature related incidents over the relevant period, the Inquiry expects the Providers

to be open and honest throughout this process and highlight any omissions to the Inquiry rather than leave their discovery to chance.

122. Given their prevalence, the investigation of ligature related incidents is a key theme that the Inquiry will be focussing on. Obtaining this data is very much the first step in investigating ligature related incidents across the Providers within the relevant period.

27 March 2025

Kirsty Lea

Counsel to the Inquiry