Summary of the Health and Safety Executive Prosecutions of Essex Partnership University NHS Foundation Trust and its Predecessor Trust

1. The Inquiry is investigating circumstances surrounding the deaths of mental health inpatients under the care of NHS Trust(s) in Essex between 1 January 2000 and 31 December 2023 ('the Relevant Period').

2. To the extent it is necessary to investigate the deaths and fulfil its Terms of Reference[1], the Inquiry will consider amongst other matters *"serious failings related to the delivery of safe and therapeutic inpatient treatment and care…"* (2a); *"the quality, timeliness, openness and adequacy of any response by or on behalf of the Trust(s) in relation to concerns…investigations… and reports (both internal and external)"* (2j); and *"the interaction between the Trust(s) and other public bodies…"* (2k).[2]

3. The following **summary** is provided as part of the evidence to be adduced at this Hearing about matters that gave rise to the setting up of the Inquiry. It is taken from evidence provided to the Inquiry by (i) Jane Lassey, Director of Regulation at the Health and Safety Executive ('HSE'); (ii) Paul Scott, Chief Executive Officer of Essex Partnership University NHS Foundation Trust ('EPUT') and (iii) other material publicly available. Later this afternoon we will also hear oral evidence from Jane Lassey.

[1] Terms of Reference (ToR) - The Lampard Inquiry - investigating mental health deaths in Essex
[2] See also List of Issues for example Sections K and L List of Issues - The Lampard Inquiry - investigating mental health deaths in Essex

4. The Inquiry is aware of two criminal prosecutions of the Essex Partnership University NHS Foundation Trust ('EPUT') or its predecessor Trust, the North Essex Partnership Foundation NHS Trust ('NEPT') during the relevant period. Both prosecutions were brought by the Health and Safety Executive ('HSE'). The prosecutions related to incidents which occurred prior to EPUT's creation (on 1 April 2017) following the merger of NEPT with South Essex Partnership University NHS Foundation Trust ('SEPT'). As EPUT assumed responsibility for its predecessors, there is no dispute that EPUT is also legally liable for its predecessors' actions. For ease of reference the defendant in both cases will be referred to as 'EPUT' or 'the Trust'.

5. At the time of these prosecutions, the inpatient units for adult mental health patients, operated by the Trust, included:

    a. The Linden Centre, Chelmsford. This contained Galleywood and Finchingfield Wards, which housed a mixture of patients who were either under section or were otherwise vulnerable as a result of being in an acute phase of mental illness.

    b. The Lakes Mental Health Hospital, Colchester. This contained Gosfield and Ardleigh Wards, which were also acute adult mental health inpatient wards.

    c. Clacton Hospital. This contained the Peter Bruff Ward, which was another acute adult mental health inpatient ward (since moved to Colchester General Hospital).

    d. Shannon House and the Derwent Centre, Harlow, which contained Chelmer and Stort Mental Health Wards, each of

which provided acute in-patient care for adults with a primary diagnosis of mental health.

e. The Christopher Unit, Chelmsford, a Psychiatric Intensive Care Unit (P.I.C.U.).

f. The Severalls House Complex in Colchester, which focused on long-term rehabilitation and included Maple Ward, part of a low-secure unit at the Willow House site.

g. The Crystal Centre, Chelmsford, which included Ruby Ward, an older persons' mental health inpatient ward.

6. The two prosecutions were:

(i) An HSE prosecution of what was then NEPT in 2014. The prosecution followed an investigation at the Derwent Centre in Harlow where an 18-year-old female patient had fallen from a window and was badly injured. The Trust was prosecuted for failures to protect service users from falls from windows that were not adequately restricted from opening. ('The 2014 prosecution').

(ii) In 2020, the HSE prosecuted EPUT for failures in respect of ligature points, which resulted in 11 deaths and one "near miss" between 1 October 2004 and 31 March 2015. ('The 2020 prosecution').

7. EPUT's Chief Executive, Paul Scott, has confirmed that he is not aware of any other prosecutions that have been brought against EPUT (or its predecessors) by the HSE or any other criminal prosecutor, since 1990

and up to the present day [Paul Scott witness statement Rule 9(14) dated 20 March 2025 can be found at page 18 of the Core Bundle].

The 2014 prosecution

8. In respect of the 2014 prosecution, it is relevant that prior to the incident, which occurred in 2013, guidance and health alerts had been issued in relation to the issue of window restraints. Window restraints, when working, should prevent windows that are within reach of patients, from opening more than 100mm.

9. Health Technical Memorandums ('HTMs') give comprehensive advice and guidance on the design, installation and operation of specialised building and engineering technology used in the delivery of healthcare. HTM 55 sets out guidance with respect to new building work for health buildings and recommended 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[3].

10. On 31 October 2007 the Department of Health issued an Estates and Facilities Alert (DH(2007)09) recommending that trusts assess the need for window restrictors in patient locations where none currently exist.

11. On 19 January 2012 another Department of Health Estates and Facilities Alert (EFA/2012/001) was issued, this time dealing specifically with restrictors with plastic spacers which, it was advised, could deteriorate.

[3] HTM 55 was replaced with Health Building Note 00-10 in December 2013.

12. On 23 January 2013, the Department of Health issued a further Health Estates and Facilities Alert (EFA/2013/002) requiring an inspection of all windows, following an incident where a patient had forced one open. The Alert required consideration of window restrictors replacements by May 2013. It was after May 2013 that an 18-year old patient fell out of the window at the Derwent Centre.

13. After the incident at the Derwent Centre in 2013, the HSE opened an investigation. On 19 December 2013, the then Chief Executive of the Trust (NEPT as it then was), Mr Andrew Geldard, was interviewed under caution. Four months later the Trust was issued a summons to attend a hearing at Chelmsford Magistrates' Court on 30 May 2014. At that hearing the Trust pleaded guilty to an offence under section 33(1)(a) of the Health and Safety at Work Act 1974 ('the HSWA 1974').

14. By their guilty plea, the Trust accepted that between 1 July 2011 and 27 July 2013 they had breached the duty under section 3(1) of the HSWA 1974 by failing to protect service users at the Derwent Centre from falls from windows which were not adequately restricted. The Trust accepted that some windows within the Derwent Centre were not restricted in line with the recommendations set out in HTM 55 and that there was no evidence of a review having taken place as required. The Trust accepted that the work could and should have been done sooner following the Health Estates and Facilities Alert in January 2013.

15. On 21 October 2014 the Trust was sentenced at Chelmsford Magistrates' Court and fined £10,000. The Trust also had to pay HSE's costs. There is no record of the sentencing remarks (this is not unusual for hearings at Magistrates' courts).

16. Paul Scott's statement lists various actions that have been undertaken since this serious incident.

The 2020 prosecution

17. An investigation that eventually led to the 2020 prosecution by the HSE was launched by Essex Police in 2016. The police investigated 25 deaths in relation to possible corporate manslaughter charges. It became a joint investigation with HSE, who were already looking into related matters.

18. In November 2018, after a police / Crown Prosecution Service decision not to charge, the investigation was taken over by the HSE.

19. The HSE then investigated inpatient ward environments under the control of the Trust, with a specific focus on the management of fixtures from which ligatures could be attached.

20. The HSE identified 11 inpatient deaths and one 'near miss' event between 2004 and 2015. Details of each of the deaths and the 'near miss' incident are not set out in this summary. There are further details to be found in the statements and exhibits provided by Jane Lassey and Paul Scott. Some of the issues are referred to below and include failures to remove known ligature points, and/or remove previous methods of creating a ligature, and or mitigating identified risks.

21. The HSE investigation learned that shortly after each death, the Trust carried out a review; a 'serious incident' (SI) or 'serious untoward incident' (SUI) investigation. In some cases, a full serious incident internal investigation panel report and action plan followed. The HSE investigation identified that ligature point audits and risk assessments

were carried out, but these reports and reviews often didn't result in actions. Time after time opportunities were missed and lessons appear not to have been learned. In at least one case, even after a death the ligature point was not removed.

22. On 12 July 2019, the HSE wrote to EPUT identifying alleged breaches of duties under section 3(1) of the HSWA 1974. EPUT was invited to provide a written response under caution.

23. On 4 November 2019, EPUT provided its written response to the HSE.

24. On 20 December 2019, the HSE wrote to EPUT confirming it had considered its response and intended to prosecute the Trust for failing to discharge the duty imposed by section 3(1) of the HSWA 1974.

25. On 19 September 2020, EPUT was charged with failing, 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 HSWA 1974.

26. The HSE's case was that the evidence available demonstrated a clear risk to the health and safety of patients. The deaths and near miss clearly proved that risk, but the risk applied to other patients during the period which formed the basis of the charge i.e. from 1 October 2004 to 31 March 2015.

27. It should also be noted that the 2020 prosecution went beyond the 11 tragic deaths and the features of the 'near miss' incident to which this summary has referred. We must also acknowledge the significant findings of the HSE investigation and prosecution which identified a

pervasive risk to vulnerable patients at mental health inpatient units under EPUT's management, for over a decade.

28. The investigation revealed that during this time, EPUT was on notice of the risks presented by fixed ligature points and the need for action to be taken to remove them. Steps taken by EPUT were inadequate and/or failed to mitigate the risks.

29. Specific failings, identified by the HSE included:

    a. Failure to comply with national standards and guidance including the Department of Health's "National Suicide Prevention Strategy" launched in 2002, which considered ligature risks (sometimes referred to as "environmental" risks),

    b. Failure to act in a timely manner when environmental risks were brought to the Trust's attention: Throughout the period covered by the HSE investigation, numerous alerts were issued drawing the attention of NHS organisations, including EPUT, to the risks from ligatures within mental health settings and the need to take action to remove them.

    c. Failure to act in a timely manner on recommendations made by the Trust's own internal Audits including a number of risk management policies and strategies in place at the Trust.

    d. Failure to act appropriately after serious incidents had occurred, by failing to make appropriate environmental changes to reduce suicide risks.

    e. Flaws in the SUI reports including that they were inconsistent, inadequate, they did not follow a set pattern, and

recommendations were not followed. The reports often failed to reference previous audits or environmental issues. The HSE found that the majority of SUI reports did not result in the necessary reduction of risk.

f. Lack of formal training in 2012/2013 around conducting Patient Safety Environmental Audits and a lack of standards and guidelines for the ligature audit. The same risks were repeatedly identified with no identified actions being taken to reduce the risks even after a patient death and when the action required was relatively simple. Risks were not assigned a risk level and /or risk levels changed despite no action being taken. Control measures weren't identified, the same risks appeared in multiple locations.

g. Repeated failures in the Annual Patient Safety Audit Reports. Failures to act with sufficient speed, or to allocate sufficient resource to resolving issues led to the same actions being repeatedly identified. Risk levels of wards did not reduce over time.

h. The HSE also relied on findings from Care Quality Commission (CQC) inspections. The issuance of requirement and warning notices demonstrated that by mid-2019 the Trust still had not taken sufficient action to remove the risks from ligature points across its estate.

30. On 20 November 2020, EPUT entered a guilty plea at the Chelmsford Magistrates' Court. The case was committed to the Crown Court for sentence. On 16 June 2021, The Hon. Mr Justice Cavanagh sentenced EPUT at Chelmsford Crown Court.

Sentencing of the 2020 prosecution

31. On 16 June 2021, the Hon. Mr Justice Cavanagh sentenced EPUT.

32. One further death, which occurred in May 2015, post-dated the indictment period, but was considered when sentencing. The fact of EPUT having a previous conviction, 'the 2014 prosecution' was also relevant to sentencing.

33. When passing sentence, the Judge had regard to the sentencing guidelines[4]. The only available sentence was a fine.

34. There was a dispute between EPUT and the HSE about where the case fell within the sentencing guidelines. Ultimately, the Judge agreed with the prosecution.

35. The full sentencing remarks can be found at page 77 of the Exhibits Bundle that was disclosed for this hearing.

36. The Judge found that the level of culpability was 'High' (the second most serious category after 'Very High') on the following basis:
    a. The Trust failed to put in place measures that are recognised standards in the industry,
    b. The Trust failed to make appropriate changes following prior incidents exposing risks to health and safety,
    c. The Trust allowed breaches to subsist over a long period of time, and
    d. There were serious and/or systemic failures within the organisation to address risks to health and safety.

[4] Sentencing guidelines can be found here.

37. When categorising the 'Harm', there was disagreement between the HSE and the Trust about the likelihood of that harm arising. The Judge put the offending within 'Level A' because of the risk and likelihood of death occurring was high, and also found that the following factors were present:
    a. The offence exposed a number of workers or members of the public to a risk of harm; and
    b. The offence was a significant cause of actual harm.

38. Therefore, the 'Harm' fell within 'Harm Category 1'.

39. In determining the level of the fine, the Judge found that the Trust was a Large Organisation (with a turnover or equivalent of £50 million and over), as opposed to a Very Large Organisation (whose turnover very greatly exceeds the threshold for Large Organisations). Its most recent annual revenue, from various sources, which was the closest equivalent to a turnover, was about £325 million.

40. The appropriate starting point and category range for the Trust, therefore, was that which applies to Large Organisations in 'High Culpability' 'Harm Category 1'. The starting point was £2,400,000 and the category range was from £1,500,000 to £6,000,000.

41. There were a number of mitigating factors including the Trust's cooperation and the remedial work that had been undertaken (it was noted that there had been significant progress after the indictment period)[5]. The fact that the Trust was a public body (and a fine would take resources away from others) was a very relevant factor and the Trust was entitled to the full one third credit for entering a guilty plea

[5] These actions have been listed at paragraph 44 onwards of Paul Scott's statement to the Inquiry – page 35 of the Core Bundle.

at an early stage. The Trust was fined £1,500,000 (£2,250,000 before the one third discount for its guilty plea). Costs in the sum of £86,222.23 (the full amount) were also ordered.

28 April 2025

Counsel to the Inquiry