Witness Name: Ann Sheridan

Statement No.: 1

Dated: 21 March 2025

Rule 9 reference: EPUT Rule 9 (7a) and EPUT Rule 9 (7b)

LAMPARD INQUIRY

FIRST WITNESS STATEMENT OF ANN SHERIDAN

I, Ann Sheridan, will say as follows: -

Introduction

1. I am the Executive Nurse within Essex Partnership University NHS Foundation Trust ('EPUT') and I have held this position since 9 February 2024.

2. I have been in employment with EPUT since 9 February 2024. I was not in EPUT's employment during the period in scope of 1 January 2000 to 31 December 2023. Prior to joining EPUT, I was employed by Central and North West London Foundation Trust where I was its Managing Director of Divisional Mental Health Services.

3. I report directly to the Chief Executive Officer ('CEO'), Paul Scott.

4. I am a registered mental health nurse, a registered general nurse, and a qualified social worker.

5. I would like to offer my sincere condolences to the families and to those who have lost their loved one under the care of mental health services in Essex. The content of my statement relates to matters of safety within EPUT and no part of the statement is intended in any way to diminish the tragic loss of life, and the ongoing suffering of the families which is felt by EPUT and its staff.

Approach to the Inquiry Rule 9 (7a) and Rule 9 (7b) Requests

6. This statement is made in response to the requests by the Inquiry to EPUT on 19 December 2024 under Rule 9(7) of the Inquiry Rules 2006 which was updated with clarification and issued on 20 January 2025, under Rule 9(7a) of the Inquiry Rules 2006. EPUT was asked to respond to a series of questions around information concerning findings of neglect and/or Prevention of Future Death (PFD) Reports, responses to such reports and related Records of Inquest (ROI) in respect of deaths falling within the Inquiry's scope, during the Relevant Period 1 January 2000 to 31 December 2023. On 13 March 2025, EPUT was asked to provide clarification on a number of questions and provide a final copy of my statement and accompanying Exhibit List.

7. In this corporate witness statement, I have provided answers to the Inquiry's questions on behalf of EPUT. Not all the matters related to the Trust are within my own personal knowledge, but I have relied on information and documents provided by colleagues and the contents of the statement are true to the best of my knowledge, information and belief. The statement also supplies information regarding the former Trusts (North Essex Partnership University NHS Foundation Trust or "'NEP", and South Essex University Partnership NHS Foundation Trust or "SEPT"). This information is sourced

directly from the electronic information or documents held by EPUT, as described further below and I have relied on the accuracy of that information, together with the searches described below.

8. EPUT is taking significant steps through searching a number of different sources to ensure we have captured as much information in relation to the matters requested by the Inquiry.

9. We have used our best endeavours in the limited time available to provide as much detail as possible and will provide any updates to this statement that may be required if further information comes to light. The details of the PFDs, adverse findings and neglect riders determined at Inquest are included where located and correct to the date of 10 February 2025.

10. My statement will be set out using the following structure:

- Section 1: Prevention of Future Deaths Reports
- Section 2: Inquest outcomes: Adverse Findings
- Section 3: Process for responding to PFDs and Inquest Outcomes
- Section 4: Learning from Inquests
- Section five: Actions on Learning from PFDs and response to neglect and adverse findings

Section one: Prevention of Future Deaths Reports

11. The Inquiry will be aware that PFD reports only began to be issued following the Coroners and Justice Act 2009, relevant sections of which came into force on 25 July 2013. Prior to this date, matters were addressed under Rule 43 of the Coroner's Rules 1984. Consistent with the Inquiry's Rule 9 request, 'PFD' as used below includes Rule 43 reports.

12. The table at **Appendix A** to this statement, which has been prepared for the purposes of this statement, provides details of PFD reports the Trust received, the date of the Trust's response, and the date of the ROI where that has been located.

13. As at the date of this statement, EPUT has located 32 PFD reports issued to the Trust or its predecessors in relation to mental health inpatients (as per the Inquiry's definition of an 'inpatient'), who are included on the List of Deceased requested under Rule 9(1) **[AS-01 – AS-32: PFD Reports]**.

14. The Trust is required to provide a written response to all PFDs within the timeframe stated in the notice. EPUT has located responses to all 32 PFDs it received, and located the accompanying documentation sent with those responses (in cases where there was accompanying documentation) **[AS-33 – AS-64: PFD Responses].** One response required a follow-up letter by EPUT to the Coroner due to an inaccuracy in the original response **[AS-65: PFD Response Correction Letter].**

15. In relation to the inquest of [I/S] although the Trust did not receive a PFD by the Coroner, the Coroner did draw a concern to the attention of EPUT. This resulted in a process of sharing information based on learning and actions with the Coroner for assurance purposes. [I/S] 's inquest concluded in [I/S] 2023, the Coroner required additional assurance with regards to learning disability/autism patient support. This was duly prepared by way of a statement issued by the Trust [I/S] **[AS-66: Witness statement]**. On request, the Trust provided further information to the Coroner [I/S] providing the progress on actions outlined in the previous Trust statement **[AS-67: Trust letter to Coroner responding to queries]**. This was duly followed up upon request [I/S] **[AS-68: Letter to Coroner]**. The Coroner confirmed he was satisfied with the assurance provided and would not be issuing a PFD to the Trust.

16. For 30 of the PFD responses, EPUT has located the documentation that accompanied the response **[AS-68 – AS-185: PFD responses documentation].** However, for two responses, some of the documentation has not been located and this is due to the period of time that has elapsed since the response was provided and changes in personnel over the period. The Trust will continue to search for this information.

17. Through searches, 22 ROIs for the 32 PFDs issued have been located and are exhibited to this statement **[AS-186 – AS-207: Records of Inquest**]. Therefore, 10 ROIs have not been located following searches of EPUT's electronic drives using the patient's name. One of the 10 ROIs that have not been located relates to an individual who was a patient of EPUT; five relate to individuals who were patients of SEPT; four relate to individuals who were patients of NEP.

18. Due to changes in organisational structure and personnel it is not possible to confirm why these 10 ROIs have not been located. Where the Trust has instructed external legal representation for cases, the relevant legal firms have been contacted in order to source the ROI, however they have also been unable to locate a copy. The relevant Coroner should hold a record of all ROIs and the Trust will continue to search for this information.

19. In addition to the 32 PFD reports directed to EPUT or its predecessor organisations, EPUT is also in possession of four PFD reports and responses from other organisations where there was no criticism of EPUT **[AS-208 – AS-216: PFDs and Responses from other Organisations].** EPUT would have received a copy of these PFDs due to the fact that EPUT was involved in the care of the patient or may have been an Interested Person at the inquest.

20. EPUT are also aware that within the PFDs, eight were issued to another body where the concerns raised by the Coroner were thought to impact on the care and treatment provided to mental health inpatients on a more national scale; five of those were also issued to the Trust, three were not. Table one displays the PFDs which have been issued to national organisations:

Table one: PFDs with national concerns

Patient identification	Issued to
[I/S] **[AS-07]**	NHS England
[I/S] **[AS-14]**	British Transport Police
[I/S] **[AS-22]**	NICE
[I/S] **[AS-25]**	NHS England
[I/S] **[AS-27]**	NHS England
[I/S] **[AS-208]**	NHS England
[I/ **[AS-210]**	Department of Health
[I/S] **[AS-214]**	NHS England and Department of Health

21. For the purposes of this statement, EPUT has reviewed the 32 PFD reports issued and has identified the following themes noted in two or more PFDs, as displayed in table two:

Table two: Themes from PFD reports

Specific issue	Number of occurrences	PFDs related to the specific issue
Record keeping	14	[I/S]

		[I/S]
Communication	9	
Clinical Risk Management	8	
Referral	6	
Investigation	6	
Family involvement	6	
Risk assessment	4	
Medication	4	
Risky item	4	
Policies	4	

		[I/S]
Care planning	4	
Environment	3	
MHA assessment	2	
Electronic Patient Records	2	
Security	2	
Training	2	
Staffing	2	
Disengagement	2	
Observations	2	

Searches conducted

22. The Trust does not hold a central record of all PFDs and ROIs issued for the entire relevant period. Correspondence with the Coroner, PFDs and ROIs were recorded on the Trust's incident management modules which have taken effect at varying times for the Trusts. Datix has been in use in the Trust since the formation of EPUT in April 2017 and was rolled out under a phased approach since June 2009 in NEP, and in SEPT since April 2010. Prior to this, systems Respond and Ulysses were utilised for incident management. NEP and SEPT Datix incident details are contained within the legacy RichClient database. Datix contains the incident details for EPUT. Due to the number of systems where such information could be stored, the Trust do not consider this to be a central filing system. Reviews have not been conducted of paper records as it is my understanding that the Trust will store such files within the electronic systems as described. The Trust has searched these available systems, and the shared drive used for inquests, to locate PFDs and responses as part of the electronic system reviews.

23. In addition to electronic system searches, a review of publicly available information on the Courts and Tribunals Judiciary website has been conducted. It is possible that the Trust would have received other PFD / Rule 43 reports, however we have been unable to locate the PFD or find indications that further reports were received within our records.

Searches have been run on the Trust's electronic drives using the patient's full name, dates which correlate with the patient's date of death and inquest date. The Trust does not have in place search software and therefore have relied upon the documents being saved with the patient's correct spelling of name.

24. Since May 2023, the Trust has in place a central record of PFDs and ROIs which consists of a catalogue and the storage of key documents within the Inquest Team shared drive.

Section 2: Inquests Outcomes: Adverse Findings

25. To determine if adverse findings have been identified at an inquest, for the [I/S] patients identified in Rule 9 (1), we have reviewed narrative conclusions. Narrative conclusions have been obtained from the ROI, where located. On occasions the wording from a conclusion is stored within electronic systems without the ROI being held, therefore the wording has also been checked using this method. Where a narrative conclusion has been reached but there are no details stored to determine if there were adverse findings, these have not been included in the analysis and figures.

26. Of the 70 narrative conclusions reviewed, 18 did not contain information pertaining to adverse findings, and a further six conclusions included adverse findings for other organisations; these have not been included within our analysis. In summary, EPUT has located:

    a. Seven inquests where neglect is a rider to the Inquest conclusion; and

    b. 39 inquests with other adverse findings for EPUT and / or its staff.

27. For these patients, the associated ROIs for inquests where neglect is a rider to the inquest conclusion or other adverse findings were made, which did not result in a PFD report are provided at **AS-217 – AS-238: Record of Inquests.** Through searches of its electronic drives, the Trust has located 22 ROIs. As previously detailed, due to changes in organisational structure and personnel, it is not possible to confirm why these documents have not been located. As noted, there are times when the Trust has instructed external legal representation for cases, although this does not necessarily explain the inability to locate the same. Where this has been identified, the relevant legal firms have been contacted in order to source the ROI. As stated above, EPUT understands that the Coroner will hold a record of all ROIs, given these are generally public documents.

28. The table at **Appendix B**, which has been produced for the purposes of this statement, lists the patient cases where adverse findings made by the Coroner. The cases in Appendix B are categorised by year. The table also sets out a brief summary in relation to each case:

    a. If the ROI is available;

    b. Summary of the inquest conclusion;

    c. Overview of the findings.

29. A review, undertaken for the purposes of this statement, has identified that the seven inquests where the conclusions included a rider of neglect, reflected a pattern of recurrence of similar issues.

30. Of those seven inquests [I/S]

    a. Three involved failures in monitoring and observation protocols.

    b. Seven involved inadequate risk assessments both at admission and / or throughout care.

    c. Seven involved lapses in care planning.

31. A table of findings and contributing factors in respect of these seven inquests is detailed at **Appendix C** to this statement.

Section 3: Process for Responding to PFDs and Inquest Outcomes

32. EPUT takes the responses and actions arising from PFDs, findings of neglect and inquests very seriously. This is reflected in the governance processes which EPUT has in place to deal with PFD reports and any related ROIs, and this includes processes where the Trust disseminates information, learning points and actions arising from PFD findings or inquest findings with adverse outcomes.

33. Due to organisational restructures and changes in personnel, it is not possible for the Trust to provide conclusive details of the processes in place across the Trust's predecessor organisations, particularly former NEP. We are unaware of historic practices within NEP and SEPT regarding inquest hearing attendance for the entire period.

34. We have been able to establish that in SEPT from 2014, a member of the Trust's Inquest Team attended hearings. For EPUT (2017), dedicated Inquest Officers represented the Trust, provided ad-hoc information to the Court and supported witnesses. The Inquest Officers were appointed based on the knowledge, skills and experience required for the role and recruited to support the process based on their career backgrounds. On-the-job training and support were provided, and since May 2023, the Inquest Team has expanded and currently operates with the addition of two trained solicitors. Following the hearing, Inquest Officers provided witnesses and court attendees with a de-brief; and this included sharing of the conclusion and learning for the individual and wider organisation. The conclusion and learning identified was communicated to the Head of Patient Safety Incident Management for escalation and inclusion in reporting processes.

35. In the former SEPT, for the period 2014 to 2017, and EPUT until 2019, during an inquest, evidence would be provided to the Coroner which included any service improvements initiated since the patient's death, whether as a direct response to the patient's death or otherwise. A member of the Trust's Inquest Team attended hearings and following the outcome would share the conclusion, findings and learning with the witnesses. Details were also shared with SEPT's Executive Operational Sub-Committee via a written report **[AS-239: ET Update – 21-27 November 19].** The Sub-Committee would consider the risks highlighted, and whether any additional measures were needed to be implemented by the Trust in order to mitigate those risks moving forwards.

36. Following an inquest, where the Coroner was not satisfied that necessary effective service improvements had been heard in evidence, they would give due consideration to the issuing of a PFD report. In circumstances where the Trust received a PFD report, this was issued to the Chief Executive and shared with the Trust's Head of Incident Management and Mortality. The Head of Incident Management and Mortality communicated the details of the PFD with the Executive Nurse, Executive Medical Director and the Chief Operating Officer. A member of the Executive Team informed the relevant Clinical Commissioning Group (CCG) of the issuing of the PFD and through evolution of improvements, this progressed to the sharing of the PFD response letter, as detailed further on.

37. Between 2014 and 2018, the PFD was shared with the service it was related to, and those with knowledge of the service and responsibility for taking actions forward assisted with the response to the Coroner. A meeting would then be led by the Head of Incident Management and Mortality with the managers and subject matter experts to discuss the learning from inquest, concerns raised by the Coroner, and actions to be taken.

Assurances were shared with the Head of Incident Management and Mortality who drafted the PFD response letter to Coroner. Once drafted, the letter was reviewed by the Executive Nurse, Executive Medical Director and the Chief Operating Officer and approved and signed by the Chief Executive for return to the Coroner via the Inquest Team or the Chief Executive.

38. From 2018, when a PFD was issued to EPUT, the communication of this was extended to include other services where the concerns and learning may be relevant. Details of the PFD report and the PFD response letter were included in a weekly report to the Executive Operational Sub-Committee **[AS-240: Weekly ET – Inquest report 26.01.2023]**. A high-level overview of the concerns raised in the PFD and response given in writing to the Coroner were also communicated and discussed in operational team meetings.

39. Where a PFD was not received but a neglect rider was returned or an adverse finding was made, this was communicated with witnesses / staff. In addition, the Trust's Executive Operational Sub-Committee received weekly reports including this information **[AS-241: Weekly ET – Inquest report 05.01.2023]**. Operational services were updated on the findings, and the circumstances that gave rise to the findings, so that they could take forward any outstanding actions identified from patient safety investigations and new information from the inquest conclusion in the services. The direction in which the learning was taken varied and was dependent upon the actions required. This included sharing of learning through the management structure, inclusion in quality and safety meetings and amendments to policy and training programmes where necessary.

40. From 2020, the Head of Incident Management and Mortality provided management and leadership of the Incident Management Team and Inquest Team, and the process outlined above continued. When the Trust adopted the Patient Safety Incident Response Framework (PSIRF) in 2021, the name of the team was changed to Patient Safety Incident Management Team (PSIM Team); and the person holding responsibility for the team had their title updated to Head of Patient Safety Incident Management.

41. In relation to PFD responses, in the three to six months after the PFD response was submitted to the Coroner, the Trust would complete a quality review of the Serious Incident (SI) action plan and the actions from the PFD. Quality reviews were undertaken by the Nurse Consultant, and from 2021, with the Clinical Lead within the Patient Safety Incident Management Team. This was to ensure that the learning and actions identified in the PFD response letter were carried out and remained embedded in practice. These

were monitored by the Patient Safety Incident Management Team alongside Serious Incident (SI) action plans; progress updates of action plans were sent to operational managers and reported into the weekly Executive Operational Sub-Committee. The Service Director was responsible for the completion of the action plan**.** Learning from inquests was also shared across clinical teams via the Patient Safety Incident Management Team's Bulletin **[AS-242: PSI Team Bulletin February 2022]**.

42. Attendance at inquests ceased in 2020 due to the Covid-19 pandemic. When attendance at inquests was reinstated, the Inquest Officers continued with the practice which was in place as described above. A practice which continued was the involvement of the appointed Family Liaison Officer who would attend the inquest to support family members where this was accepted or requested. Where concerns or queries were raised which could not be answered in the scope of the inquest, the Family Liaison Officer would extend and offer for these issues to be reviewed by the Trust where relevant.

43. Coupled with the increase in the number of inquest hearings post-pandemic alongside the revised governance structure for all Trust learning, the process for the management of PFDs was reviewed. The review was undertaken by the Interim Inquest Manager and Executive Nurse from February 2023 and incorporated observations and learning from the former PFD response process **[AS-243: PFD process - 2023]**. The review identified the need to continue the working group, as outlined above, to respond to the PFD as this was an element which had worked well previously; it also included additional steps whereby the working group would review the draft response to the PFD before sharing with the legal representative of the inquest. The response letter was approved by the Executive Nurse and finally by the Chief Executive before submission to the Coroner. The process was presented to the Patient Safety Incident Executive Assurance Group in May 2023. Regular meetings were scheduled with the Integrated Care Boards (ICBs) to share inquest learning, conclusions, and PFDs and responses, and these meetings have continued to the present date with an agreed agenda drawn up **[AS-244: ICB Joint Assurance Group Agenda]**. In addition, EPUT provides a quarterly report to the ICB Trauma Informed Mortality Group to provide details of new PFDs and progress with action plans. This commenced in December 2024 **[AS-245: PFD update Feb 2025].**

44. The management of patient safety investigations and inquests remained integrated until the teams separated in January 2023; the Head of Patient Safety Incident Management retained patient safety incident investigations, and an Interim Inquest Manager was appointed to oversee the inquest and PFD processes.

45. In May 2023, the Associate Director for Legal Services joined the organisation and took oversight of the inquest and PFD processes. On commencement with the Trust, the Associate Director of Legal Services noted a variation in the standards of learning / PFD evidence being provided to the Coroner by way of witnesses and learning evidence.

46. In addition to the above process review, further amendments were made and have since incorporated all inquest learning, including neglect and adverse findings.

47. The Inquest Team hold a debrief session at the conclusion of every inquest; following this an email is sent to the staff witnesses, copying in service managers, directors, the Director of Patient Safety, Learning Lessons Team and the Trust's Here for You Psychological Support Team providing:

    a. A case summary

    b. Primary inquest issues

    c. Lessons to be drawn from expert opinion / internal report (as appropriate) and note any considerations around escalating matter to Patient Safety Incident Management Team for retrospective investigation / review reports (as appropriate)

    d. Inquest outcome

    e. PFD position (if applicable)

    f. Other relevant matters (for example challenges around locating staff / documentation standards / locating relevant policies)

    g. Training identified

    h. Learning and improving

    i. Requesting feedback on the service and support received from the Inquest Team

48. In relation to the PFD response sign off process and PFD action planning and monitoring, the following changes were made:

    a. Following receipt of the PFD, this is shared with clinical services who are responsible for drafting the response, which is prepared for final review / approval, then sent to the Medical Director's Office so that this reply may be further scrutinised and reviewed by the following colleagues:

        I. Executive Medical Director

II. Executive Nurse

III. Senior Director(s) for the service

IV. Inquest Team Lead

b. A sign-off meeting is held to discuss any changes or additions. Thereafter, the agreed draft is sent to the Chief Executive for final review and signature before being filed at court.

49. The service is then issued with a PFD action plan template to complete in order that they may monitor / track the actions / assurances as set out in the PFD reply **[AS-246: EPUT Prevention of Future Death Action Plan Template Feb 2024].**

50. The Trust has been listening and learning as it continuously improves the processes of learning and embedding change from patient deaths and inquest experiences. To support this learning, we are updating the current PFD response process which has been trialled since September 2024. This is detailed in the flowchart last updated in November 2024 **[AS-247: PFD Process Flowchart**]. The process is currently being reviewed by the Director and Associate Director responsible for the Inquest Team. Feedback and learning are being analysed, and improvements are being made and will be completed by April 2025. From information received to date, no significant changes will be made to the process.

51. The Executive Operational Sub-Committee, Safety of Care Group and Trust Board of Directors receive PFD reports to ensure that they are sighted on all PFD related matters and actions being taken across EPUT to address the findings, including copies of the PFD documents **[AS-248: Claims and Inquests Reports Dec 2024; AS-249: PFD Report - Board of Directors Dec 2024; AS-250: PFD Report Jan 25 – ET**].

Section 4: Learning from Inquests

52. Whilst the Trust has been able to demonstrate learning from incidents which have led to change in practice, EPUT has seen a rise in the number of PFDs being issued over the recent years. In some cases, PFDs have been issued as a result of lessons not being learnt or evidenced regarding earlier incidents / cases.

53. A common theme in respect of PFDs being issued, is that the Trust has been unable to provide the required assurances to the Coroner around lessons learnt, and embedding these Trust-wide. To provide a structured plan to address identified themes at inquest, the Trust formed an Advisory Group (AG) which was set up in August 2023 and concluded in February 2024. Its aim was to engage with subject matter experts

and senior managers to gather information to address the objectives set out within the AG's Terms of Reference, which was to afford the Trust with their expertise in supporting and assuring implementation of improvement to promote safer patient care. The AG action plan provides an overview of the outcomes and actions taken forward **[AS-251: Prevention of Future Deaths Regulation 28 Advisory Group Draft TORs August 2023; AS-252: PFD Advisory Group Action Plan].**

54. The Executive Team were updated and the findings from the Group formed part of the two-day Inquest Awareness sessions so that key issues could be shared. The invitation to these sessions were opened Trust-wide across clinical and corporate services; 160 staff attended across two dates in July and November 2024. A further session is scheduled for April 2025.

55. Following the conclusion of the AG in February 2024, to ensure robust and meaningful learning evidence is provided to the Court, a mapping meeting was held in December 2024 to agree membership for the Core Group (CG). The first CG meeting was held in January 2025 **[AS-253: TOR PFD Witness Core Group]**. This group will take the lead in respect of the Trust's PFD evidence at court in respect of the various areas of service delivery. The aim of this refreshed approach is to provide a more informed approach to PFD evidence and to consider any overlaps in assurances; this will enhance the Trust in being able to pick up themes from inquests and embed learning across the Trust in partnership with the Lessons Team. Above all, the objective of the CG will be to promote safer patient care.

Culture of Learning

56. Under the Safety First Safety Always Strategy, EPUT saw the introduction of the Culture of Learning. Since August 2022, EPUT has had a Learning Collaborative Partnership (LCP) which is managed by the Trust's Learning Lessons Team. **Exhibit AS-254: Learning Collaborative Partnership Group Terms of Reference** provides the current Terms of Reference for the group. The LCP meets monthly, and lessons from a variety of sources impacting both staff and patient safety are shared at this forum.

57. The Inquest Team reports monthly into the LCP. This includes an overview of the number of inquests attended, PFDs received, and the key learning points and themes obtained from hearings **[AS-248– Claims and Inquests Report Dec 2024]**. During the meeting, LCP members review submissions of learning and together determine an effective method of learning to be shared and who that learning should be shared with. Examples of shared learning include a monthly newsletter and 5 key messages poster **[AS-255 – AS-257: 5 Key messages and lessons newsletters].**

58. The current reporting structure for LCP includes a monthly report into the Learning Oversight Sub-Committee (LOSC). The Lessons Team also report outcomes from LCP into quality and safety meetings which take place monthly within the care units; where they discuss matters pertaining to the quality and safety of the patients within their services. The care units are responsible for ensuring this is cascaded to individual teams. An overview of learning is provided from LCP by the Lessons Team into these forums for key themes of learning to be shared up, down and across the organisation **[AS-258: Inquest and PFD Governance Chart; AS-259: Culture of Learning Quality and Safety Report; AS-260: Learning Collaborative Partnership Group Assurance Report for LOSC].** In addition, Executive Operational Sub-Committee reports contain outcomes of inquest and PFDs **[AS-250: PFD Report Jan 25 – ET].**

59. To further strengthen the tracking and sustainability of PFD actions and learning, the Trust has incorporated PFD actions into its CQC Action Leads meeting since 2024. This meeting was set up in response to meet the complex set of 'Must do/Should do' improvement actions issued by the CQC in July 2023 following inspection in November 2022, and feeds into the fortnightly Executive Assurance Group which has ICB oversight and final sign off **[AS-261: CQC Action Plan].**

60. There was significant engagement when developing and implementing the CQC improvement plan, with over 100 staff involved (66% of which were clinicians) and positive feedback received from staff. Through teams taking ownership and developing robust action plans, it was identified the same process could be followed for PFD action plans to bring further levels of robustness, and also to aid operational colleagues in having key actions plans in the same system, which helps to avoid duplication, gives operational colleagues additional corporate support in development and implementation, and provides one place for both sets of plans. All open PFD action plans moved into the master action plan in June 2024; which is held as a master document on a shared Microsoft Teams channel, which all leads for delivering on the improvements, can update on in 'live-time' on one visible version **[AS-262: PFD Master Action Plan – Working Document].**

61. A component of this 'evidence assurance process' is a presentation of the evidence to ICB quality leads for impact at service level in terms of the improvement for patients and staff, and that changes are embedded and assessed as sustainable before being closed. The ICBs provides partnership system-based solutions, check-and-challenge and external scrutiny. The aim was to ensure operational ownership and leadership for actions, utilisation of System Engineering in Patient Safety (SEIPS) processes to ensure

good understanding of the factors that lead to the action being identified, focus on long term sustainable changes and increased focus on improvements **[AS-263: SEIPS Explanation]**.

Patient Safety Investigations and Learning

62. As previously stated, in May 2021, the Trust moved to the Patient Safety Incident Response Framework (PSIRF) 2022 and was one of the first 'early adopter' NHS trusts to introduce PSIRF. This has replaced the Serious Incident Framework (SIF) 2015 and represents a significant shift to a more compassionate engagement and involvement for those affected by patient safety incidents. The Trust committed to ensuring that it fully embedded PSIRF requirements and used the NHS England Patient Safety Response Standards (2022) to frame the resources and training required. This included having a dedicated Nurse Consultant for Patient Safety & Patient Safety Specialist role who holds accountability for ensuring the Trust is adhering to national standards and being appraised of national guidance changes. The implementation plan led to the recruitment of a Director of Safety in 2021 and the establishment of a Learning Lessons Team in 2022.

63. The Trust previously operated a centralised investigation model that completed a majority of the investigations into patient safety incidents. This approach had at times disempowered local clinical team ownership of patient safety incidents and embedding learning at a local level; preventing the local care unit leadership team having the right level of scrutiny and responsibility. In addition, with a central team completing most investigations this can lead to the quality and timeliness of the investigation outcome being impacted. Therefore, to ensure that the patient, family and staff experience is strengthened, and responsibility sits within the senior leadership team of the relevant care unit, in 2024 the Trust enhanced the investigative and learning responses capacity locally. This was supported by five permanent trained Patient Safety Leads employed and line managed across all care units. These staff serve as a resource of skills and expertise to support locally trained staff conduct good quality patient safety incident investigations working alongside patients, families and frontline staff. There are weekly PSIRF Oversight Group meetings led by the Director for Patient Safety with care unit leadership to discuss incidents, review decisions made on level of investigations and agree immediate learning across the Trust. This meeting includes external scrutiny from ICB members **[AS-264: PSIRF Oversight Group ToR]**.

64. The care units are supported by the dedicated Patient Safety Incident Management Team (PSIM) consisting of a Head of Patient Safety Incident Management as well as

a senior PSI Investigating Officer and a lead Family Liaison Officer, supported by a Nurse Consultant reporting into the Director for Safety. This team provides Trust oversight and scrutiny to ensure that appropriate support is being offered to staff, patients and families involved in the patient safety incident. This team provides assurance to the Quality Committee that PSIRF is being delivered to the highest standards and reports on patient safety incident learning responses and outcomes. This will include reporting on ongoing monitoring and review of the PSIRP and delivery of safety actions and improvement.

65. Involving patients, their families and carers, and other lay people as safety improvement partners is a key strand of the National Patient Safety Strategy. EPUT has over 200 involvement representatives with a number of those undertaking additional training to become Patient Safety Partners (PSPs). PSPs are members of a number of Executive level groups including the LOSC, LCP and Safety Improvement Plan Oversight Group. They also co-produce policies, attend quality support visits, and provide support in testing the embedding of learning following patient safety events providing valuable oversight and representing the patient and carer voice.

66. The Trust PSIRP prescribes an approach for local priorities for learning responses. Included in this approach are a pre-defined number of incident types that will be reviewed collectively following the Patient Safety Incident Investigation (PSII) response, and then thematic reviews of the findings would aggregate the data for inclusion into a Safety Improvement Plan (SIP). The SIP would describe the activities involved in implementing, monitoring and evaluating the effectiveness of any agreed safety actions.

67. In 2023, the Trust formalised its governance and oversight process and each SIP designated an Executive lead. All safety improvements within these SIPs are developed in collaboration with other services which operate across boundaries including co-designing and co-delivery with patients, families and staff and those responsible for implementation and improvement. All safety actions are monitored by a named individual responsible for these. This work is supported by building on best practices and utilising work already undertaken at a regional and national level. Details of the Trust's current SIPs are described as follows:

- Ligature Risk Reduction
- Falls Risk Reduction
- Transition from CHYPS to Adult Services

- MDT Communication Gap
- Record Keeping
- Clinical Handovers
- Policies and SOPs
- Patient Disengagement
- Medication Incident Risk Reduction
- Discharge and Transfers

68. All safety actions and safety indicators are monitored by the PSIM Team through the Safety Improvement Plan Oversight Group, reporting through the Safety of Care and Effectiveness of Care Groups for oversight into the Quality Committee. SIPs are maintained as dynamic and agile documents. They have specific target dates for completion, but in order to meet the challenges of maintaining safe systems and responding to emergent issues, they may iterate over time.

69. The SIPs are monitored through the Safety Improvement Plan Oversight Group, which is achieved by:

- Providing a governance infrastructure to analyse the themed learning relating to all SIPs identified through PSIRF and documented in the Trust's PSIRP.
- Adopting and maintaining system thinking principles to improving patient safety outcomes.
- Moving away from a linear cause and effect thinking and ineffective person focused safety actions toward one which includes understanding of work system interactions, performance influencing factors, thus creating effective system focussed safety actions.
- Identifying Trust-wide and local actions to address the learning.
- Populate the programme of work on LifeQI ensuring input from the subject matter expert within all the SIP themed areas.
- Submitting progress reports to LOSC.
- Agreeing evidence required to provide assurance of action.

70. The Deputy Directors of Quality and Safety and identified SIP leads attend meetings regularly and provide verbal and written updates on the work with operational services across the Trust to ensure implementation of necessary actions to deliver the SIP:

- Meeting monthly to monitor progress of implementation, identifying achievements / any areas requiring remedial action / issues for escalation to LOSC.
- Ensuring areas for remedial action are taken forward and monitor progress, initiate and close completed SIP themed activity as indicated in the SIP process map.
- Providing a monthly report of progress / issues / risks to LOSC.
- Identifying, managing and monitoring any risks to achievement of the SIP themed areas.
- Identifying any change ideas to be added to the SIP Programme of Work and LifeQI Driver Diagram to develop areas of the management system to enhance patient safety.
- Agreeing appropriate corporate communication / activities to promote the delivery of the SIPs and transformation of safety and clinical practice across the Trust.

Learning Lessons Team

71. The Lessons Team was set up in 2022 and is committed to creating the conditions that will support effective learning and embed change in practice. The Lessons Team work with all teams and subject matter experts to innovatively consider how learning can be captured, analysed, raised or resolved, and embedded within a practice. Its lead chairs the Learning Collaborative Partnership meeting to discuss learning across the organisation. The group is made up of staff across the Trust and creates an opportunity for embedding a Culture of Learning in the Trust. The LCP provides oversight and governance for decision making on content of the 5 key messages and lessons identified newsletter. The key role for each LCP member will vary in relation to their specialist area and the context in which lessons are identified. At a minimum, each member has a remit to ensure emerging themes are identified and resolved in a timely and efficient manner.

72. The LCP feeds into the LOSC which is responsible for assurance on aggregating learning from incidents, including those from inquests, and that these are discussed

and shared. The group may also recommend further action for other committees, the care unit leadership, specific leads for training, ongoing work streams and teams. LOSC monitors the activities in relation to embedding the processes outlined in PSIRF, works with the care units to evaluate the improvements against the learning identified. Group members will be asked to collate and share learning from their own areas to facilitate discussion at each meeting.

73. Outside of the LCP meeting, the Lessons Team has other methods of cascade which are reactive to the learning identified. Safety Learning Alerts are shared with relevant managers via Datix and contain information of learning identified, actions which need to be taken, and confirmation that action has been taken is logged within Datix. By way of an example, in July 2022, the Lessons Team developed a Safety Learning Alert directly following learning from an inquest **[AS-265: Safety Learning Alert: Learning from Inquest].** This was to share details of the learning from inquest with all staff working in clinical operational roles in community and inpatient services. This involved a risk assessment was not in place at the time of the patient's admission to the acute inpatient ward which led to missed opportunities to recognise the risk the patient presented with. Themes of record keeping and actions to be taken within each team to ensure the learning was shared were detailed. Actions were also shared with the reader of the alert (e.g. including the use of new records management monitoring tools). Through Datix, the Lessons Team can view the number of responses to the alerts, and for this alert, 76% of managers responded to inform action had been taken. Responses are monitored via Datix; non-responders were identified and prompted for the action taken to be recorded on Datix. Responses were discussed at LOSC and taken to the local care unit quality and safety meetings, whereby managers were informed of areas where a response had not been recorded so this could be prompted. For non-responses, accountability is within the leadership structure with oversight from the Deputy Directors for Quality and Safety for the care units. The Trust has identified that there are areas for improvement in the governance and structure for the closure on Datix which is currently being addressed.

Section five: Actions on Learning from PFDs and response to neglect and adverse findings

74. Below we have set out the actions taken in response to the neglect / adverse findings which have proved to be effective. We have focused on examples from the current Trust, rather than its predecessor organisations.

Thematic analysis of PFDs

75. A thematic analysis was completed examining the findings of nine PFD reports issued by the Coroner, spanning from 2021 to 2024. The concerns highlighted the need for clear roles and responsibilities for care coordinators, adequate training and support for their roles, the importance of effective communication and collaboration with other care providers and involving patients' carers in the care planning process. The Trust employed a methodological approach that combines manual thematic analysis with machine learning or AI cross-referencing techniques to enhance the depth and efficiency of the analysis, cross-check and validate the findings, ensuring comprehensive coverage and accuracy. The actions taken in response to the Coroner's concerns were reviewed and mapped against the SIPs to promote continuous improvement. It was identified, that whilst some of the actions have been completed and fully embedded in practice, some actions require a longer period for completion **[AS-266: Thematic analysis of 9 PFDs].** The findings were presented at Quality Together in June 2024; a meeting between EPUT, ICBs and NHS England to provide a collective approach in improving and sustaining quality and safety. The presentation was also presented to Quality Committee in June 2024, the Trauma Informed Mortality Group in September 2024 and the Learning from Deaths Oversight Group in October 2024.

Learning from Inquest: Physical health in mental health settings

76. The link between physical health and mental health is well documented; and a factor which the Trust recognise the importance of, and a theme acknowledged from incidents and inquests. In inpatient settings, the Trust has invested in the recruitment of 196 registered general nurses who have brought their expertise into the mental health wards, along with the recruitment of a Deteriorating Patients and Resuscitation Lead in 2022, as a direct outcome from a patient inquest. This role has seen the engagement in the LCP, the facilitation of debrief and learning post-incident, and the strengthening of revised policies and procedures to reflect updated resuscitation guidance and the use of the National Early Warning Scoring System (NEWS2) **[AS-175: Clinical Guidelines on the Use of NEWS2. V2.1 [2018-2025]**. In September 2022, an internal Safety Learning Alert was published to all staff working in inpatient community health and mental health units. The alert contained an acknowledgement of events where staff had been required to perform Cardiopulmonary Resuscitation (CPR) and positive feedback which had been shared by Ambulance crews. Learning opportunities had been identified and good practice shared. This included:

- Staff members who located a patient, who was unresponsive and not breathing, quickly called upon their colleagues for support
- The grab bag and ligature cutters were obtained with minimal delay
- Ambulances were called promptly
- Staff from other wards responded and offered their support in a timely manner
- Staff members rotated while performing chest compressions
- Staff demonstrated good teamwork. This included support from students and non-clinical staff who managed entrance and exits, supported and engaged with other patients, obtained equipment and came together as a team
- Staff administered oxygen and doctors were present in rapid time
- Clear communication, handovers to Ambulance crews and strong leadership were noted
- Staff initiated and engaged with debrief sessions after CPR attempts. They supported each other during and after events. Staff were signposted to support available to them following incidents of this nature.
- Staff have reported that being involved in medical emergency drills was beneficial

77. The alert **[AS-267: Medical Emergencies Safety Action Alert]** provided an overview of further learning opportunities related to the importance of conducting observation and engagement and the use of Oxevision as an assistive technology; awareness and recognition of risk, triggers and deterioration; grab bags being collected at the sound of an alarm raised; the use of a communication tool when communicating with the Ambulance Service via a mobile phone; strong communication and leadership in task allocation and situational awareness; the creation of a supportive environment where staff feel comfortable to speak up and challenge; the benefits of mandatory training to improve knowledge and experience and the requirement to undertake CPR simulations. A short Basic Life Support algorithm chart was also included with signposting to the relevant services for further input should teams or individuals require it.

78. In 2023, the CPR Policy and Procedure saw the introduction of ‘calling (9)999 in a medical emergency’ which was created in collaboration with the Ambulance Service and followed learning from inquest. The one-page flow-chart is designed to be printed

and displayed on wards for staff to follow should an event arise where it is necessary **[AS-268: Calling (9)999 in a medical emergency].**

79. Drop-in sessions were launched in January 2023 to provide doctors, nurses, support workers, allied health professionals and students with an opportunity to ask questions related to the care of deteriorating patients or resuscitation on an ad-hoc basis or following a response to a medical emergency, at the request of a ward or as part of a structured visiting arrangement over a number of sessions **[AS-269: Drop-in refresher sessions].** The face-to-face attendance on mental health wards includes the facilitation of medical emergency simulations and life support and deteriorating patient refresher sessions to help achieve training compliance, whilst providing an opportunity for staff to have the simulation and subsequent learning discussions facilitated by a Resuscitation Council UK 'Advanced Life Support' Instructor. Outside of visits, should staff wish to raise queries or concerns about deterioration of a patient, resuscitation or comorbidities, they can make contact with the Head of Deteriorating Patient Pathways & Resuscitation Training Officer and with other subject matter experts within relevant areas of specialism, such as for diabetes, wound care management and sleep apnoea as examples. This is in addition to out of hours or emergency care required.

80. In addition, the Trust utilise Safety Huddles to promote and proactively respond to the changing needs of individuals and the ward environment. They are used as a quick and effective way to share issues and concerns and support patient safety and the management of escalating situations. This provides an ad-hoc platform where actions are agreed related to a number of concerns, including physical health, mental health, and environmental needs of the patient group and ward as examples.

81. In November 2024, Physical Health Link Practitioners were implemented and will act as a link between Trust physical health groups and wards; promoting best practice, raising awareness and empowering teams to enhance their physical health knowledge and skills. The Physical Health Link Practitioner's role is help facilitate learning about a patient's physical health condition and directing staff to resources such as NHS England education bite sized learning, and if patients present during admission with a physical health diagnosis, the Physical Health Link Practitioner can guide staff to ensure patient care plans include physical health needs and identify any knowledge needs or the engagement of subject experts in the care planning processes where identified. This is a responsibility to be undertaken as part of staff's existing roles, and they provide support within inpatient and community services. The number of Physical

Health Link Practitioners varies across each of the wards as part of the ongoing program expecting to see new practitioners on-boarding this role.

Learning from Inquest: Leave Risk Assessments

82. Prior to merger, the Trust implemented the Leave Risk Assessment Tool which was used to review a patient's risk before they utilised leave from an inpatient setting. The use of the tool has been incorporated into record keeping audits to ensure the risk assessment is completed to Trust standards. In December 2018, the Trust introduced the 'My Care, My Leave Plan' document, a collaborative discussion and planning tool between the patient and inpatient clinicians, to outline leave arrangements such as destination and return date and time; a patient's favourite places that they may visit whilst on leave; contact numbers for the ward should the patient be running late for their expected return time; agreed telephone number for the ward staff to contact the patient and crisis numbers. The document is a Trust document which is printed for completion between the patient and nursing staff and is stored in the nursing offices alongside the patients 'My Care My Recovery' document for easy access and reference for the staff, and a copy is retained by the patient. 'My Care My Leave Plan' is reviewed on an individual basis with the patient when circumstances, needs or risks change **[AS-138: My Care, My Leave Plan].**

83. In April 2024, following a thematic review of inpatient safety incidents and unexpected deaths between 2014 and 2024, operational managers included the identified themes into the Therapeutic Operating Model to provide staff with an overview of learning and improvements which have been embedded and will continue to be sustained **[AS-136: Therapeutic Acute Inpatient Operating Model for Adults and Older Adults].** The need for effective risk assessment continues to be identified as a key area of focus for continuous clinical improvement.

Statement of Truth

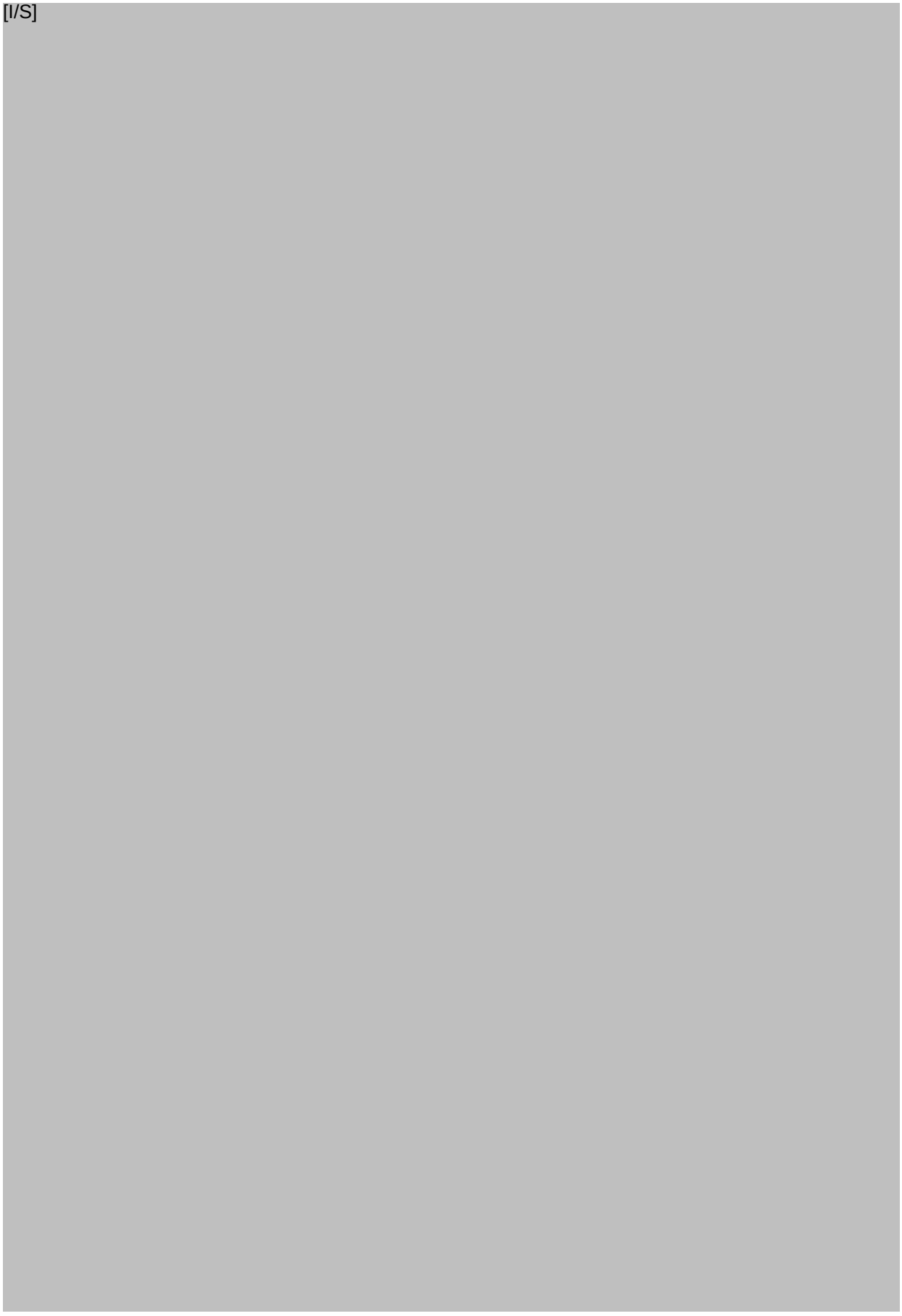
The content of this statement is true to the best of my knowledge and belief.

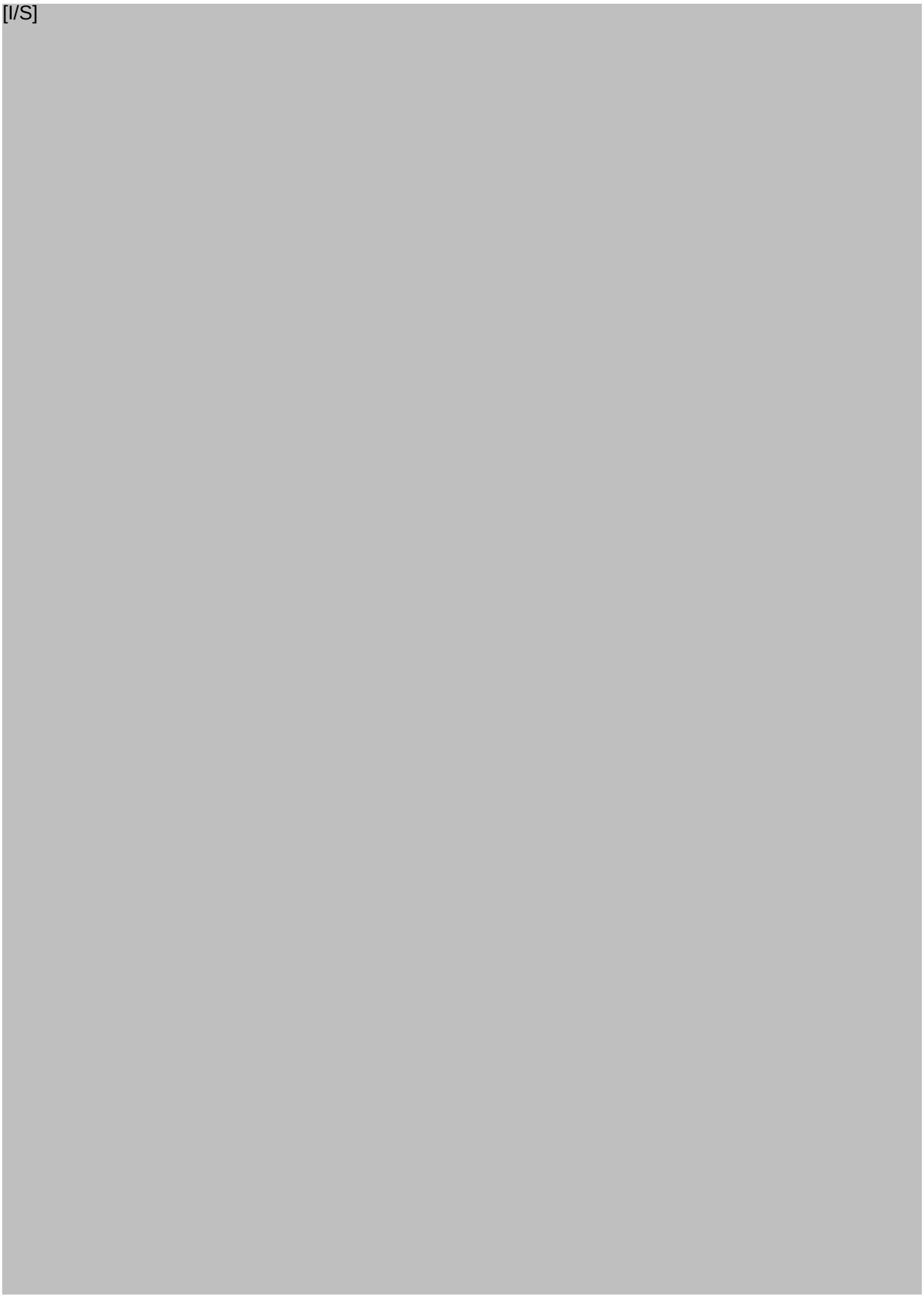
Signed: [I/S]

Dated: 21.03.2025

Appendix A – PFDs, Responses and ROIs

[I/S]




[I/S]

Appendix B – Adverse Findings

	Patient name	Date of death	Date of Inquest	ROI held	Summary of the adverse findings
1	[I/S]			No	Inadequate precautions to prevent absconsion; failure to account for the condition of paranoid schizophrenia in the precautionary measures
2				No	Uncooperative due to mental health with deterioration in physical health; patient died of pulmonary embolism and DVT before further tests were carried out
3				No	Inadequate system for carrying out recording, and monitoring neurological observations, which fell below acceptable professional standards
4				No	Policy and procedural shortfalls may have contributed towards her death
5				No	A number of factors which contributed to the patient incident
6				Yes	Systemic and procedural shortfalls by those responsible for her care
7				Yes	Incomplete transfer of risk assessment leading to lower level of observation; failure to remove belt;

	[I/S]		inadequate bedroom environment allowing for barricading and suspension
8		Yes	The handovers, follow ups and lack of communication between organisations contributed to service user's death.
9		Yes	Risk of suicide not adequately assessed, lack of precautions against suicide
10		Yes	Failure to adequately assess his risk of self-harm and suicide
11		Yes	Missed opportunities to fully assess her level of risk
12		Yes	A failure to perform health and safety checks A lack of observations and communication, not considering [I/S]'s condition Inadequate staffing levels below those authorised by the Trust
13		Yes	Failure to properly assess the patient's mental state, inadequate communication with the patient's family, failure to verify the patient's claims about family support, failure to ensure a safe discharge plan.
14		Yes	Lack of autism-focused approach in mental health assessment and care planning, Failure to consider the impact of autism on [I/S]s presentation and communication,

	[I/S]	Failure to recognize the increased suicidality risk in individuals with autism, Failure to make reasonable adjustments for [I/S] autism, Failure to account for autism-informed input on substance use, Failure to consider detaining [I/S] under Section 3 of the Mental Health Act, Flawed decision to allow [I/S] to discharge himself without sufficient safety measures, Inadequate assessments of [I/S] mental capacity, Failure to involve autism specialists in capacity assessments, Failure to involve [I/S] mother in capacity assessments and address her concerns, Inappropriate and unprofessional judgements regarding [I/S] mother and her home environment, Failure to document and communicate serious concerns about [I/S] safety, Failure to communicate grave concerns to relevant staff, including the Consultant Psychiatrist.
15		Notwithstanding his presentation when visited at home it was considered that his acute mental health crisis and his risk of suicide could be safely managed in the community

16	[I/S]	No	Lack of follow-up after discharge, Absence of discussion with the SMHT doctor, No treatment plan review in the community, Delayed risk assessment, Lack of discussion in SMHT multidisciplinary team meetings, Failure to review medication, Care Coordinator's role not reallocated promptly
17		Yes	Failure to communicate the full nature and extent of the risks [I/S] posed, including impulsive self-harm and suicide, in the letter from her Consultant Psychiatrist to the hospital clinicians, Lack of a written care plan from the Eating Disorder (ED) and/or Specialist Community Mental Health (SMH) Teams addressing known risks related to [I/S] diagnoses, such as AN-driven behaviours and EUPD-driven impulsivity No provision of a written care plan to the Acute Medical Team or Mental Health Liaison Team (MHLT) at the hospital before her admission, Absence of the Eating Disorder Specialist Nurse, with whom [I/S] had a longstanding relationship, during a critical period of her care.

18	[I/S]	Yes	Absence of specific risk assessment for supervised access to knives, Absence of focused risk assessment for unsupervised access to knives before transfer to Aurora ward, Failure to conduct a focused risk assessment for unsupervised access to knives after transfer to Aurora ward, Inadequate consideration of known potential triggers for [I/S] mental deterioration, Missed opportunity to assess the cumulative effect of multiple factors on [I/S] mental health.
19		Yes	Recent increase in risk, and records were not adequately reviewed prior to assessment
20		Yes	Incomplete risk assessments regarding [I/S] care, Inadequate Oxevision training and failure to convey its limitations, Lack of an effective system to record training completion, Failure to monitor the quality of observations and recordings, Lack of clear roles and responsibilities for nightshift staff,

	[I/S]		Failure to carry out effective level 2 observations and engagement, Misuse of Oxevision as a substitute for face-to-face observations, Failure to attend to bathroom alert alarm in a timely manner, Amendment of observation records to falsely indicate engagement, Failure to properly conduct observations and engagements, possibly affecting the outcome.
21		Yes	Not receiving an appointment with a Psychiatrist and being assessed by the Psychiatrist

Appendix C – Analysis of Inquest findings with a neglect rider

	[I/S]							Case Analysis
Risk Assessment	Failure to complete risk assessment	Inadequate risk assessment Profiling bed not clinically required and ligature points not removed	Inadequate: Premature discharge without addressing suicidal ideation. Insufficient follow-up after discharge; downgraded to SMHT prematurely. Mental Health Act assessment not conducted during crisis; insufficient crisis management	The decision not to admit [I/S] was an obvious and conspicuous missed opportunity to keep him safe at a point of clear and unambiguous mental health crisis. No support was offered to [I/S] or his family by way of a detailed crisis or safety plan in the face of [I/S] clear and on-going deterioration in his mental health. This was a very serious failure indeed, amounting to a gross failure to	Inadequate quality and accuracy of recording	Failure to adequately follow up a plan identified in an assessment; lack of follow up led to a failure to conduct a full MDT meeting with a missed opportunity to allocate a care coordinator and update care plan and risk assessment	When reduced to Level 2 and Level 1 observations the correct risk assessments including room checks were not completed	(7/7) showed failures in risk assessment at admission and / or ongoing care

				provide basic medical care				
Observations	On transfer, staff were unaware of the level of observations prescribed on the previous ward (level 3) Failure to involve the Consultant Psychiatrist in the decision to downgrade observations	Not applicable	Not applicable	Not applicable	Level 3 observations [I/S] were inadequately conducted due to obstructed eyesight, lack of engagement, and failure to monitor breathing, with no justified reason for keeping the door closed.	Not applicable	Staff observations being falsified led to [I/S] not being checked and she felt staff did not have time for her. [I/S] critical observations were missed.	(3/7) showed procedural failures in monitoring and observations.
Family Involvement	Family involvement not mentioned	Family involvement not mentioned	Family not consulted during Section 2 discharge or Gatekeeping assessment.	Failure to respond to family members concerns regarding medication and suicidal thoughts	Family involvement not mentioned	Family involvement not mentioned	Family involvement not mentioned	(2/7) failed to consult family members at critical decision points, resulting in missed opportunities for holistic care
Treatment Planning	Incomplete handover Lack of collaboration	No specific care plan to mitigate ligature risks; Unnecessary profiling bed	Pharmacological treatment inconsistent; no psychological input.	Insufficient practical steps taken to develop an appropriately robust and thorough-going	Failure to document and communicate his sleep apnoea,	Failure to undertake urgent medication review despite repeat	Transition to adult services poorly managed; known triggers	(7/7) demonstrated inadequate treatment planning, exposing

	between professionals Inability to access patient records on the electronic patient record systems	contributed to the risks.		Care Plan or a clear and appropriately detailed and up-dated formulation of risks.	medication risks, and care needs, which impacted the ability of staff to provide appropriate monitoring and intervention.	requests with decline from Consultant to complete	and changes ignored.	systemic shortcomings in care continuity and implementation
Emergency Response	Not mentioned	Missed opportunity to rescue[I/S] at the point at which he was found [I/S] as a result of an inadequate emergency response Delayed emergency response, improper use of Bag Valve-Mask (BVM) The failure to use the mask to administer	Not mentioned	Not mentioned	Failure to observe and respond to signs of respiratory distress in a timely manner, including repositioning JS and escalating concerns, likely contributed to his death	Not mentioned	Oxevision alerts were muted leaving her unsupervised for 50 minutes	Emergency protocols were either delayed, ignored, or mismanaged in 3/7 of the cases.

		oxygen in a timely manner						
Key Contributing Factors	Poor handover, inadequate risk assessment and observation, access to electronic patient record systems	Requirement to be in a profiling bed not met by clinical need; ligature points within the profiling bed were not removed; emergency response	Poor communication, lack of multidisciplinary collaboration, system driven pressures to discharge prematurely.	Identified deterioration in mental state without robust risk planning, family concerns not acted upon, medication not reviewed to assist with increase in symptoms	Inadequate documentation Poor communication, Failures in Level 3 observations , Lack of timely intervention, Gross failure in basic medical care.	Increased risk and care planning not followed through, medication review not offered to manage symptoms	Falsified observations, procedural noncompliance, inadequate transition planning	Highest contributing factors across the patient cases: Risk assessment, treatment planning