

For the attention of the Chief Executive
Essex Partnership University NHS Foundation Trust
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Telephone: 03000 616161
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05 February 2026

The Care Quality Commission
The Health and Social Care Act 2008
SECTION 29A WARNING NOTICE:
Provider: Essex Partnership University NHS Foundation Trust

Regulated activities:

Assessment or medical treatment for persons detained under the Mental Health Act 1983
Treatment of disease, disorder or injury

Our reference: ENF2-000000003840

Account number: R1L

Dear Paul,

This notice is served under Section 29A of the Health and Social Care Act 2008.

This warning notice serves to notify you that the Care Quality Commission has formed the view that the quality of health care provided by Essex Partnership University NHS Foundation Trust for the regulated activities above requires significant improvement:

The Commission has formed its view on the basis of its findings in respect of the healthcare being delivered in accordance with the above Regulated Activities at the locations identified below:

439 Ipswich Road
Colchester
Essex
CO4 0HF

The reasons for the Commission's view that the quality of health care you provide requires significant improvement are as follows:

Regulation 13, Safeguarding

Regulation 13 (1)

Service users must be protected from abuse and improper treatment

1. Staff failed to report safeguarding incidents appropriately. On 22 March 2022 patient A was exposed to inappropriate staff conduct. On 15 May 2023 staff reported concerns that staff member A was developing a close relationship with patient B. On 29 August 2023 concerns were raised that staff member A was spending time in patient C's bedroom. On 15 September and 01 October 2025 patient D and patient E reported money missing. Patients were advised to lock bedroom doors, but no further action was taken. Failure to report safeguarding incidents exposes people to risk of abuse and improper treatment.
2. From April 2020 to May 2025 there were 12 incidents reported about inappropriate behaviour and sexual safety concerns involving staff member A. Staff failed to identify appropriate actions to prevent ongoing harm. On 28 April 2020 a concern was raised about sexually inappropriate behaviour. A disciplinary decision-making tool was completed but immediate actions were not identified. On 5 May 2022 staff member B reported that staff member A had inappropriate material on her phone while at work. Photographic evidence was provided. It was decided that there was not enough evidence to support the allegation. There were 3 previous concerns regarding behaviour of staff member A. In August 2023 a new concern about an inappropriate relationship of staff member A was raised. This was discussed in supervision, but no further action was taken. There continued to be concerns raised after this date, which are still being investigated. Failure to identify and implement actions from investigations puts patients at risk of abuse and improper treatment.

Regulation 17, Good governance

Regulation 17 (2)(a)

Assess, monitor and improve the quality and safety of the services provided in the carrying on of the regulated activity

1. Managers did not have adequate oversight of staff. Supervision compliance was an average of 46% from May to October 2025. On 18 August 2022 an investigation identified supervision as an action to address concerns about staff not wanting to report incidents to staff member B. There is no evidence this discussion took place in supervision. Staff did not receive regular supervision or appraisals. Supervision was not effective in managing concerns and staff conduct issues. Appraisal compliance was 40% from May to October 2025.
2. There was lack of management oversight. There were gaps in clinical audits. For example, ward manager audits were not completed for 4 out of the last 12 months.

17(2)(b) Assess, monitor and mitigate the risks relating to the health, safety and welfare of service users and others who may be at risk which arise from the carrying on of the regulated activity.

3. Managers did not have adequate systems in place to monitor the assessment of risk. Systems did not give staff tools to put mitigation in place and to keep patients safe. Staff told us patients were placed inappropriately at 439 Ipswich Road, due to bed shortages on other wards. We raised this concern during our inspection and risk assessments for patient F and patient G were reviewed in their absence. Failure to have systems in place to ensure assessment of risk puts patients at risk of avoidable harm.
4. Managers did not have robust oversight of incidents. They had missed opportunities to improve the quality and safety of the services provided to patients as outlined in point 1 and 2. This meant people were exposed to ongoing harm. Staff were not assured that managers would appropriately manage risk. Staff did not follow processes when reporting incidents, due to lack of confidence that leaders would take action to mitigate risk to patients.
5. Concerns relating to the health and safety of the environment were not effectively actioned, putting patients at risk of avoidable harm:
 - a) There was a large hole in the garden fence, providing an opportunity for patients to abscond. On 28 May 2025 a patient raised this as a concern and had disclosed "a wish to die" but no urgent action was taken. Following our inspection, we raised concerns that patients detained under

the Mental Health Act 1983 could abscond and no urgent action was taken to mitigate this risk.

- f) Fire risks were not appropriately identified or managed. An emergency fire exit was covered with a black bin bag, due to patients reporting the light was shining into their room. In the laundry room, items such as a pillow were stored directly behind the washing machine and tumble dryer.
- f) Ligature risks were not appropriately identified or mitigated. There was a shed in the garden and the door did not shut. There were hose pipes and other items in the shed that were a risk to patients. When we raised this as an immediate safety concern, the shed was temporarily screwed shut to mitigate risk. As of 16 January 2026 the shed door had not been fixed with a permanent solution. There were broken appliances in the garden that had not been disposed of and were a risk to patients. Some broken appliances had long electrical cables, which were a ligature risk. Managers had to be prompted to make the environment safe during inspection.
- f) Due to some patients not being assessed on admission their risk of self-harm and suicide was unknown and unable to be mitigated. There were no ligature cutters in the Coach House.
- f) Cleaning liquids were not safely stored. We found cleaning liquid in a paper cup in a kitchen cupboard in the Coach House.
- f) Managers did not enforce safety processes. Not all staff were wearing personal alarms. There were no alarms around the building in the event of an emergency.

Why you need to make significant improvements in safeguarding (regulation 13):

- Patients were not safeguarded from abuse and improper treatment. Appropriate safeguarding authorities were not always notified of safeguarding incidents. Full investigations did not always take place so there were missed opportunities to protect people. Where investigations did take place, appropriate actions were not always identified. Where actions were identified, they were not always completed to safeguard patients from ongoing risk of harm. Investigations after incidents did not protect patients from abuse and safeguarding authorities were not always notified of safeguarding incidents. Repeated safeguarding incidents took place with one staff member, and appropriate measures were not taken to address their behaviour and safeguard patients.

Why you need to make significant improvements in good governance (regulation 17):

- Systems and processes were not operating effectively to assess, monitor and improve the quality and safety of the service. Risk assessments were not always completed, and risks were not always known. Staff were not assured that managers would take action when incidents and concerns were reported. The environment was not safe and patients were at risk of avoidable harm. A lack of oversight and governance meant CQC identified risks for the staff to address. You have failed to ensure there were adequate governance processes in place to identify these issues and take remedial action, which put patients at risk of avoidable harm.

You are required to make the significant improvements identified above regarding the quality of healthcare by Thursday 30 April 2026.

Please note: If you fail to comply with the above requirement and thereby fail to make significant improvement to the quality of the health care you provide within the given timescale(s) we will decide what further action to take against you. Possible action includes:

requiring Monitor, now known as NHS England and NHS Improvement, to make an order under Section 65D (2) of the National Health Service Act 2006 (appointment of trust special administrator).

We will notify the public that you have been served this warning notice by including a reference to it in the inspection report. We may also publish a summary more widely unless there is a good reason not to.

You can make representations where you think the notice has been served wrongly. This could be because you think the notice contains an error, is based on inaccurate facts, that it should not have been served, or is an unreasonable response. You may also make representations if you consider the notice should not be published more widely.

Any representations should be made to us in writing within 10 working days of the date this notice was served on you. To do this, please complete the form on our website at: www.cqc.org.uk/warningnoticerepresentations and email it to: HSCA_Representations@cqc.org.uk

If you are unable to send us your representations by email, please send them in writing to the address below. Please make it clear that you are making

representations and make sure that you include the reference number ENF2-000000003785

If you have any questions about this notice, you can contact our National Customer Service Centre using the details below:

Telephone: 03000 616161

Email: HSCA_Representations@cqc.org.uk

Write to: CQC Representations
Citygate
Gallowgate
Newcastle upon Tyne
NE1 4PA

If you contact us, please make sure you quote our reference number ENF2-000000003785 as it may cause delay if you are not able to give it to us.

Yours sincerely

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[I/S]

Operations Manager