Terms of Reference

The Essex Mental Health Independent Inquiry will review the care and treatment pathways and the circumstances and practices surrounding the deaths of mental health inpatients.

The Inquiry will investigate the deaths which took place in mental health inpatient facilities across NHS Trusts in Essex between 1 January 2000 and 31 December 2020. It will draw conclusions in relation to the safety and quality of care provided locally and nationally to mental health inpatients.

The Inquiry intends to publish a report in spring 2023. The Inquiry will provide regular updates on its progress and may highlight matters requiring urgent attention.

The issues the Inquiry will consider are:

1. key factors that led to the deaths of mental health inpatients who were under the care of the Trust(s), including care and treatment pathways;
2. the role, involvement, and communication with the patient and their families, carers, or other members of their support network in the patient's care;
3. the culture, leadership, and governance that may have impacted on the ability of the Trust(s) to improve inpatient safety, treatment, and care and reduce inpatient deaths;
4. the quality of previous investigations into mental health inpatient deaths, the conclusions and recommendations of those investigations, and the response by the Trust(s) and the wider system;
5. recommendations for the Trust(s) to ensure action is taken so that current and future mental health inpatients receive appropriate and safe treatment and care; and,
6. further recommendations for the Trust(s), mental health services, the NHS, and the wider system.

Explanatory Note to Terms of Reference

Introduction

This note has been written to accompany the Terms of Reference and to explain the definition of some of the terms used.

On 21 January 2021, the Minister for Patient Safety, Suicide Prevention, and Mental Health set out a statement to the House of Commons. (A copy of the Minister's statement is at Annex 1). The statement confirmed that she would establish an independent inquiry into mental health inpatient deaths in Essex. The Minister stated that the Terms of Reference for the Inquiry would be recommended by the Chair, once a consultation had taken place with those affected.

The consultation on the Terms of Reference ran from 26th May to 3rd August 2021. This was a public consultation open to anybody to participate in.

The Inquiry team reached out to and heard from affected families, patients, local community groups, charities, and other individuals and organisations with an interest in the issues laid out by the Minister. The Inquiry also placed adverts in the local media inviting people to come forward and share their views. The Inquiry team have reviewed relevant material obtained for the Terms of Reference from a number of sources.

Draft Terms of Reference were published on 20th July 2021 and circulated to those who had expressed an interest in the Inquiry. They were also available on the Inquiry website and in hard copy.

The format of the Inquiry as non-statutory was not a matter for this consultation and has already been the subject of unsuccessful challenge by way of a claim for judicial review (CO/1413/2021).

The Inquiry team are grateful to all of those who took the time to share their views and provide information to the Inquiry.

We understand that the subject of the Inquiry can be very distressing for those affected by the loss of a family member or friend within a mental health unit. The subject matter may also be difficult for those who are current or former mental health patients within the Essex area. The Inquiry team have all received trauma informed engagement training and we encourage anyone who wishes to provide their views to come forward. You will be treated with dignity and respect.

Key Definitions

Trust(s)

The Inquiry uses the term Trust(s) to refer the NHS trusts which operated in Essex between 2000 and 2020. This includes the North Essex Partnership University NHS Foundation Trust, the South Essex Partnership University NHS Trust, and the Essex Partnership University NHS Foundation Trust which took over responsibility for mental health services in Essex from 2017. You may also see these shortened in Inquiry documents to NEPT, SEPT and EPUT.

Timeframe

The Inquiry has been established to consider deaths which took place between 2000 and 2020. There may be limitations to the extent to which the Inquiry will be able to investigate deaths which took place during earlier years in this timeframe. This may be because relevant information and data relating to those who have died may not be available for example, due to the way in which it was recorded and stored.

National Picture

The Essex Mental Health Independent Inquiry will review the circumstances and practices surrounding the deaths of mental health inpatients in Essex as case studies, to draw conclusions in relation to the safety and quality of care provided both locally and nationally to mental health inpatients. The Inquiry will also review a small number of select comparator areas to consider how Essex mental health inpatient care compares with other parts of the country.

Care pathways

For the Inquiry to adequately investigate the deaths of mental health inpatients, we cannot look at their time on the ward in isolation. We must consider all phases of their care.

Exactly what this “pathway” looks like will be different for each individual. Each person will have had interactions with many different services, individuals, and organisations both within the NHS and beyond. By considering the pathway, the Inquiry will take a holistic view of each individual and their journey through the health and care system.

Wider System

Caring for those experiencing mental ill health is not solely the work of NHS providers of mental health services. A patient's experience of care is informed by a much wider range
of individuals, organisations, laws, policies, and frameworks.

These include:

- bodies that undertake the needs assessments, commissioning, planning, and standard setting of mental health care;
- providers of the care and treatment of mental health patients in all sectors;
- bodies that are responsible for the oversight, governance, regulation, and improvement of safety, quality of care, and services;
- bodies responsible for setting and improving relevant policies and frameworks; and,
- other individuals, organisations, or responsible bodies that patients and their families, carers, or other members of their support network interacted with in the patients care and/or through any complaint process or investigation.

Terms of Reference.

1. **Key factors that led to the deaths of mental health inpatients who were under the care of the Trust(s), including care and treatment pathways**

The Inquiry has been established to focus on deaths which occurred in mental health inpatient units in Essex.

The Inquiry uses the term “inpatient deaths” to include:

- those who died within acute mental health inpatient units;
- those who died while on leave from a mental health unit;
- those who died following transfer from a mental health inpatient unit to a physical health unit (including A&E) or to an out of area mental health service;
- those who died during a period when they absconded or were absent without leave from a mental health inpatient unit;
- those who died while awaiting an assessment under the Mental Health Act or while waiting for a bed in a mental health inpatient unit following a clinical assessment of need;
- those who died up to 3 months following discharge from a mental health inpatient unit.

The Inquiry intends to include the following within its remit:

- the Inquiry will consider those individuals who died in circumstances which were unexpected, unexplained, or self-inflicted;
- the Inquiry will also consider the deaths of children and young people who died within inpatient child and adolescent mental health services in the Trust(s).

The Inquiry does not intend to include within its remit:

- patients who died in older adult inpatient care from natural causes;
- individuals who died in the community, other than where they fall under the definition of inpatient listed above.

The level of investigation into each death may vary dependent on:

- the circumstances of the death;
- any particular issues of concern identified;
- any views which we receive from the family and carers (both formal and informal);
- the pathway into care;
- the nature of any records or data held; and,
- the availability of relevant evidence.

In order to meet the Terms of Reference and to provide comparators, the Inquiry may consider evidence which relates to individuals who died outside the Essex area as well as those who died within the community in Essex.

2. **The role, involvement, and communication with the patient and their families, carers, or other members of their support network in the patient's care**

The Inquiry wishes to place patients and their families, carers, or other members of their support network at the heart of its work. Understanding the role and involvement of patients and their families, carers, or other members of their support network will help the Inquiry identify good practice and poor practice and enable it to make recommendations to improve patient care for the future.

This will include the role of patients and their families, carers, or other members of their support network in relation to the creation and implementation of care plans, the treatment received in an inpatient setting, as well as any plans for discharge. It will also include support through any complaints processes and/or investigations.

3. **The culture, leadership, and governance that may have impacted on the ability of the Trust(s) to improve inpatient safety, treatment, and care and reduce inpatient deaths**

The Inquiry will take a comprehensive approach to consider the Trust(s) culture, leadership, and governance. Investigation will include, but not be limited to, the relationship between Senior Leaders at the Trust(s) and the mental health units, the patient experience, workforce practices, and the design, implementation, and operational application of policies and procedures.

4. **The quality of previous investigations into mental health inpatient deaths, the conclusions and recommendations of those investigations, and the response by the Trust(s) and the wider system**

A number of investigations are undertaken by different organisations following the deaths of mental health inpatients. These include, for example, serious incident reports, inquests, CQC investigations, Parliamentary and Health Service Ombudsman reports, and other internal, local, regional, and national reports. The Inquiry may consider these investigations including their scope, methodology, findings, and how any recommendations were communicated. The Inquiry will assess the response of the Trust(s) and whether this was adequate and effective. The Inquiry will also examine any recommendations made by Coroners and the response of the Trust(s). The Inquiry does not intend to revisit in any detail those matters which have been investigated by the police.

5. Recommendations for the Trust(s) to ensure action is taken so that current and future mental health inpatients receive appropriate and safe treatment and care

The Inquiry intends to take a comprehensive look at factors which could have contributed to deaths or which constituted serious failings in patient treatment, care, or safety. In addition to the families and friends of those who have died, we welcome views from current or former mental health inpatients and members of healthcare staff to help us with this area of work.

Through our consultation, the following issues have been raised with the Inquiry team in connection with the provision of safe treatment and care within mental health inpatient units. The box below provides examples of the issues raised so far but is not an exclusive list of issues the Inquiry will investigate. Additional issues may be added as the Inquiry's investigations progress.

- Sexual safety (including safety from sexual assault and inappropriate sexual behaviour);
- Management of self-harm and suicide attempts;
- Environment and environmental risks;
- Use of restraint and restrictive practices within inpatient units;
- Medication practices and management;
- Management of physical health treatment and care;
- Search procedure for patients on mental health wards;
- Record keeping (including patient medical records);
- The speed and effectiveness of clinical assessment;
- Reporting practices;
- Multidisciplinary working;
- Care Plans, Treatment Plans;
- Ward level application of policies and clinical guidance. Including related to search, ligature points, observations, and ward leave;
- Involvement of patients and their families, carers, or other members of their support network in health care and care planning;
- The experience of raising concerns or complaints including support received through any investigation process;
- Staffing levels, capacity, skill-mix, culture, and performance;
- Support, training and supervision provided to staff;
- Capacity within mental health units across Essex;
- Communication and handover of care between staff and clinicians within mental health inpatient units;
- Information sharing where there has been any transfer of care. For example, between mental health teams and services, physical health hospitals including A&E, out of area services or other Trust(s), and social services;
- Information and data sharing with relevant individuals, organisations, and professional bodies.

In the written statement given on 21st January 2021, the Minister confirmed that the Inquiry would not reopen the investigation of fixed potential ligature points that has given rise to the prosecution of Essex Partnership University NHS Foundation Trust by the Health and Safety Executive. The Inquiry recognises that this is an important area of concern for many families and intends to consider evidence in relation to ligature risks and the steps taken by the Trust(s) in response in considering environmental risks.

6. Further recommendations for the Trust(s), mental health services, the NHS, and the wider system

The Inquiry will review the circumstances and practices surrounding the deaths of mental health inpatients. This will include investigation into the care and treatment pathways of mental health inpatients and, therefore, the Inquiry may uncover areas for improvement beyond the inpatient setting.

The Inquiry aims to make clear, concise, and actionable recommendations to improve mental health care not only within Essex, but also across the NHS and the wider system.

ANNEX I

Statement made on 21st January 2021 by Nadine Dorries the Minister for Patient Safety, Suicide Prevention, and Mental Health, announcing an Inquiry.

The Parliamentary and Health Service Ombudsman (PHSO) published his report "Missed opportunities: What lessons can be learned from failings at the North Essex Partnership University NHS Foundation Trust" on 11 June 2019 which found that there were a series of significant failings in the care and treatment of two vulnerable young men who died shortly after being admitted to North Essex Partnership University NHS Foundation Trust. I have previously announced my commitment to an inquiry into these tragic events.

Today, I am announcing the establishment of a non-statutory, independent inquiry into the circumstances of mental health in-patient deaths at the former North Essex Partnership University NHS Foundation Trust, the former South Essex Partnership University Trust and the Essex Partnership University NHS Foundation Trust, which took over responsibility for mental health services in Essex from 2017. This will cover the period from 1 January 2000 to 31 December 2020.

In announcing this inquiry, I am mindful of the current, extraordinary demands on the NHS as it responds to the worst pandemic in living memory. The Essex Partnership University NHS Foundation Trust was one of the first to declare a major incident and the inquiry will schedule its work in a way that is sensitive to these pressures.

I have also listened carefully to the arguments proposing a more formal, statutory inquiry into these events. I share the desire for a robust and independent process that will get to the truth and deliver the necessary learning. I remain convinced that a non-statutory, independent inquiry is the best way to do this and identify the necessary improvements in the timeliest way.

I have asked the distinguished psychiatrist Dr Geraldine Strathdee CBE to chair the inquiry and am delighted that she has agreed to take on this important role. Dr Strathdee worked for many years as a consultant psychiatrist in the NHS. She brings a wealth of experience in mental health policy, regulation and clinical management and is a co-founder of the Zero Suicides Alliance. Dr Strathdee is a person of the utmost integrity and I will expect her to conduct this inquiry without fear or favour. In order to ensure her independence, she will step down from her current role as a national professional adviser at the Care Quality Commission when her term ends in March of this year.

The chair will be supported by expert advisers, including a legal adviser.

The inquiry will consider issues including:

- the key factors that led to the deaths of individual patients, whether issues of omission or commission;
- aspects of culture and governance that inhibited the trust(s)' ability to learn and take action following any breaches of safety;

- the quality of any previous investigations by the trust(s), the conclusions and recommendations of those investigations and the subsequent actions;
- the response of the wider system to these events and the actions taken by the trust(s) in response to investigations or reviews conducted by any other body; and
- the further lessons for the Essex Partnership University Foundation NHS Trust and what actions are necessary for the new trust chief executive and its board to ensure that current and future patients receive sustainable safe care; and
- further lessons arising for the mental health services, the NHS and the wider system.

The inquiry will not reopen the investigation of fixed potential ligature points that has given rise to the prosecution of Essex Partnership University NHS Foundation Trust by the Health and Safety Executive but may consider the evidence in this area.

The inquiry will be able to interview witnesses to determine if there were failures in care, safety, governance or professional standards and will examine all relevant records to get to the truth. We owe the families nothing less.

My Department will co-operate fully with the inquiry's investigation, including provision of any documents it might hold that are relevant to these issues and are requested by the inquiry.

Similarly, all NHS employees will be expected to give the inquiry their full co-operation.

I am moving forward with this important inquiry in order to shine a clear light on what happened at the trusts so that lessons can be learnt by the current trust and the NHS more widely. These lessons must be applied to the trust and the NHS to ensure that the provision of mental health services is improved and, critically, that lives are saved. This will require the investigation of some, possibly all, mental health in-patient deaths that occurred across the county between 2000 and 2020. Our focus must be on how we learn the lessons to improve services and prevent in-patient deaths in the future. The chair will want to consider what level of scrutiny of individual deaths is necessary to do this. However, there may be limits on the scrutiny that is possible of the earlier deaths that occurred during this period.

The chair will recommend a final terms of reference following consultation with the families and others affected by these events which I will communicate to Parliament in due course.

The inquiry will be formally established from April 2021 and will aim to report in the spring of 2023.