Essex Partnership University
NHS Foundation Trust

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CONFIDENTIAL
Mrs Caroline Beasley-Murray
HM Senior Coroner
Seax House, Coroner's Court
Victoria Road South
Chelmsford Essex
CM1 1QH

Dear Mrs Beasley-Murray

I am writing to set out the Trust's formal response to the Regulation 28: Report to Prevent Future Deaths, dated 14 August 2017, which was issued following the inquest into the death of Mr Terence Pimm. Sadly, Mr Pimm died while he was a patient of the former North Essex Partnership University NHS Foundation Trust. This Trust was dissolved when it merged with another Trust on 1 April 2017 to form Essex Partnership University NHS Foundation Trust. I am the Chief Executive of this new Trust, but did not hold any position in the former North Essex Partnership University NHS Foundation Trust.

I would like to begin by extending our deepest condolences to the family of Mr Pimm. We fully understand that this has been, and remains, an extremely difficult time. I hope this response provides them and you with assurance that the Trust regards this situation very seriously and is taking action to address the issues raised in the inquest.

I have responded below to the matters of concern relating to the former Trust:

- **Call handling and record-keeping at The Lakes:**

All health-based place of safety calls are directed now through the new Trust's call centre. This means that all calls are recorded and documented on a call-log by trained call-handlers.

All patients admitted to health-based places of safety have individual patient records detailing potential risks, assessment of presentation and copies of documentation from other agencies. Further work is continuing on electronic record-keeping processes in regard to this issue.

- **To mental health assessors as to the circumstances in which the input of family members should be sought:**

The new Trust has taken steps to reinforce to staff the importance of family involvement and ongoing communications. A detailed debrief in this respect was undertaken with the staff involved in Mr Pimm's care. Additionally, audits on this issue are being undertaken via the new Trust's staff supervision process.

- **The sufficiency of information sharing and coordination between the police, hospital Trust and probation service:**

The information-sharing concordat has been reinforced. Additionally, the new Trust holds localised police liaison emergency care meetings and will ensure that the probation service is invited to improve information sharing in this regard.

The new Trust has launched a new street-triage team in which mental health practitioners work together with dedicated police officers. We anticipate that this initiative will also help significantly to improve information-sharing and coordination between our services.

- **Training/ guidance for mental health clinicians in relation to persons who are subject to a warrant:**

A new flowchart is in place now for staff, which details clearly which actions to take in situations where people are subject to a warrant. Training on this is underway for all our staff working in mental health accident and emergency teams and mental health criminal justice teams.

Please be assured that learning from Mr Pimm's death is being shared across the new Trust to help prevent the same issues arising again.

Finally, I would like to reiterate my condolences once again to Mr Pimm's family at this very sad time. I hope that this response goes some way to providing assurance that the Trust regards their loss very seriously indeed and is taking steps to address the issues raised during the investigation and the inquest.

Yours sincerely

SALLY MORRIS
Chief Executive