

NHS Trust fined following failures to manage environmental risks

Essex Partnership University NHS Foundation Trust (EPUFT) has been fined for failing to manage environmental risks within its mental health inpatient wards. These breaches were committed by North Essex Partnership University NHS Foundation Trust (NEPUFT) before EPUFT came into existence.

Chelmsford Crown Court heard that, between 25 October 2004 and 31 March 2015, NEPUFT failed to effectively manage recognised risks from potential fixed ligature points in its inpatient wards, resulting in mental health patients being exposed to unacceptable and avoidable risk at a time when they were most vulnerable. Tragically eleven inpatients died during this timeframe whose deaths involved access to fixed ligature points.

An investigation by the Health and Safety Executive (HSE) found that NEPUFT failed to adequately identify, or address with sufficient urgency, the significance of the environmental risks within its inpatient wards.

Essex Partnership University NHS Foundation Trust of The Lodge, Lodge Approach, Runwell Wickford, Essex pleaded guilty to breaching Section 3(1) Health and Safety at Work Act 1974. The Trust was fined £1,500,000 and ordered to pay costs of £86222.23.

“I hope this case acts as a reminder to all mental health trusts of the need to continue to review their current arrangements and ensure their service users receive the protection they need at, what is often, their most vulnerable time.”

Det Chief Insp Stephen Jennings, the Senior Investigating Officer who led the Essex Police investigation into the North Essex Partnership University Foundation Trust (NEPUFT) welcomed today’s sentencing. He said: “I hope the conclusion of this HSE prosecution against NEPUFT, which we have supported throughout, now gives the families time to continue to grieve in peace.

“Following a full investigation, which began in 2017, into the circumstances of a number of deaths, and following expert legal advice, the evidential threshold was not met to allow us to take the Essex Police investigation any further. However, we ensured all of the evidence we had gathered was given to our HSE colleagues to support their investigation and it has unquestionably helped to secure this result.”

Notes to Editors

1. The Health and Safety Executive (HSE) is Britain's national regulator for workplace health and safety. We prevent work-related death, injury and ill health through regulatory actions that range from influencing behaviours across whole industry sectors through to targeted interventions on individual businesses. These activities are supported by globally recognised scientific expertise. www.hse.gov.uk
2. More about the legislation referred to in this case can be found at: www.legislation.gov.uk/
3. HSE news releases are available at <http://press.hse.gov.uk>
4. Until the 1 April 2015, decisions whether or not to investigate patient safety matters in England were made in line with our HSWA Section 3 policy: <http://www.hse.gov.uk/enforce/hswact/priorities.htm>. After this date, the Care Quality Commission (CQC) became the lead inspection and enforcement body under the Health and Social Care Act 2008 for safety and quality of treatment and care matters involving patients and service users in receipt of a health or adult social care service from a provider registered with CQC.
5. HSE has not investigated individual patient deaths. Where a patient death appears to have been possible due to access to a ligature point, HSE reviewed the suitability of the arrangements that were in place at that time to manage this risk in relation to relevant health and safety legislation.
6. The investigation timescales predate the existence of Essex Partnership University NHS Foundation Trust which came into existence when North Essex Partnership University NHS Foundation Trust (NEPUFT) merged with another trust.

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