Essex Partnership University
NHS Foundation Trust

23 July 2025

Chief Executive Office
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Wickford
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Tel: [redacted]

Private and Confidential
Ms Sonia Hayes
HM Area Coroner for Essex
Coroner's Office
Seax House
Victoria Road South
Chelmsford
CM1 1QH

Dear Ms Hayes,

Julie Sheila Beasley (RIP)

I write to set out the Trust's formal response to the report made under paragraph 7, Schedule 5, of the Coroners and Justice Act 2009 and regulations 28 and 29 of the Coroners (Investigations) Regulations 2013, dated 28 May 2025 in respect of the above, which was issued following the inquest into the death of Julie Beasley (RIP) .

I would like to begin by extending my deepest condolences to Ms Beasley's family. The Trust sympathises with their very sad loss.

The matters of concern as noted within the Regulation 28 Report have been carefully reviewed and noted. I will now respond in full to these concerns in the hope that this provides both yourself and Ms Beasley's family with comprehensive assurance of changes that have been made at the Trust to address the concerns you have raised.

Concern 1)
Mrs Beasley was seen at home following a call to the mental health crisis team and required a full V4 mental health assessment that did not take place and instead an SBAR review was completed, and the nurse did not scrutinise the medications and medication changes that had been previously made and made errors about the doses. Mrs Beasley was informed she was discharged back to her GP, but no actions were sent by the mental health Trust to the GP.

Response:
The Trust has continued to review our assessment processes to ensure that the appropriate reviews are undertaken in a timely manner and are supported through the MDT approach which then supports a joined up approach to patient assessments. Staff in the Mental Health Crisis team are required to undertake a mental health assessment for *all* patients, which is monitored and audited via supervision meetings and compliance reviews.

Further, the Trust issued a Trust-wide safety alert, in respect of Electronic Assessment Documentation, which re-enforces and reminds colleagues that all sections of the Initial Assessment form should be completed or a clear rationale for why it is not possible to complete a section should be given e.g *'Patient is unable to provide this information at present due to their current presentation'.*

The expectation is that a full and robust Biopsychosocial assessment is completed for all patients requiring an assessment (for which there are clinical polices which corresponds with

the Trust approved assessment documentation). The audit and monitoring of this expectation is detailed below.

In addition, the Trust has developed a new electronic handover tool process which will aid clearer documentation and clarity in respect of follow up actions.

By way of evidence provided to the Court, the team have clear processes for GPs to be emailed following any patient contact. Clinical staff are supported by the Team administrative personnel who are tasked with sending assessment details to GP's, which includes highlighted actions.

A process has also been initiated whereby communication is not sent to an individual, but will be sent to the MDT. This ensures there are no delays in communication / actions requiring attention.

Monitoring of the quality of assessments, noting the **concerns above** has been enhanced with monthly assessment quality audits. The audits are evidence based (NICE Guidance) and undertaken by each lead reviewing 10 cases each month. The lead will feedback to staff the themes they have found, good practice and areas for improvement, as a means of 'spot checking' the assessments that are being carried out. In addition to the team monthly audits, An EPUT wide audit carried out in April 2025 for urgent care, showed overall for the 5 teams, sections regarding Patient Details, Consent & Capacity, Carers, Referral Details and Assessment attained results at 91% or above regarding compliance.
Alongside this we have been supporting all registered clinicians across our urgent care pathways to access STORM training, storm training is a three day training course focussed on safety assessment, formulation and planning. As part of our trust year 1 priorities for suicide prevention we set a target of 50% by April 2025 of registered urgent care practitioners completing the 3 day training, this was achieved. Compliance in June 2025 reported an increase to 73% compliance of training attendance in this area against a target of 95% to be achieved by April 2026. The Trust's plan to achieve full compliance includes an increase of Trust facilitators training. A further 8 facilitators commence in September 2025, increase training capacity.

Concern 2)
Following this Mrs Beasley contacted crisis mental health explaining that she had vital information that she had not shared following a visit by a psychiatric nurse at her home. Mrs Beasley was not asked what the information was. Mrs Beasley contacted the crisis team again a few days later repeating that she had not shared information and again was not asked what the information was and was not given an appointment. Mrs Beasley's telephone contacts were noted in her medical record with no details recorded as to what the additional information Mrs Beasley wanted to share. Mrs Beasley did not receive the appropriate psychiatric assessment following her contact with the crisis team.

Response:
A Quality and Learning event, Trust wide for urgent care teams has been held. This included Crisis Response and Home Treatment team leaders, clinical managers and service mangers.

This event was led by the Director of Quality and Safety and Operational Associate Director on the 19th August 2024 with a focus on assessment and family involvement. A follow up Urgent care away day took place on 1st May 2025 to review all learning, data and incident reporting across 2023- 2024 for urgent care to ensure joined up thematic learning and review.
The scrutiny of deadlines and impact continues to be reviewed at the monthly Urgent care Quality and safety meetings.

The learning that has been derived from this case, has been taken forward so as to ensure, we pick up and note the lessons to be learnt including the review of systems and processes.

Again, adherence to policy which includes the management of calls by the Crisis Team, is monitored via supervision meetings and audit. Such reviews also highlight expectations for full and clear documentation and the need to apply professional curiosity when new information is being offered. The reviews also help inform and feature in our urgent care quality improvement plan.

The Service is currently seeking to apply for Royal College standard accreditation, which provides a robust evidence based framework for service delivery. The Quality Network for Crisis Resolution and Home Treatment Teams aims to work with teams to assure and improve the quality of crisis resolution and home treatment services for people with acute mental illness and their carers.

The Trust Community Response Home Treatment Policy is currently under review as part of routine review processes, the learning to be taken from this case will be considered as part of the review.

By way of further assurance, reflective supervision is being undertaken with the individual staff member who did not speak with Mrs Beasley.

Concern 3)
Mrs Beasley was conveyed to hospital having taken an overdose of medication and was reviewed by the Trust mental health liaison team.

Review of the mental health Trust medical records would have shown that Mrs Beasley had an SBAR review rather than a V4 mental health assessment. This should have alerted staff to the fact that an urgent assessment was required when Mrs Beasley attended mental health liaison following an overdose of her medication. This did not happen.

Response:
We refer to the reply set out under concern 1 above, namely that the Trust has continued to review our assessment processes to ensure that the appropriate reviews are undertaken in a timely manner. Additionally, the Mental Health Liaison Service have been reminded of the requirement for a V4 assessment to be completed for all patients. Team Leads will seek the advice of HR in respect of any individual staff concerns as required, in light of the need to ensure correct and adequate documentation is completed in a timely manner. Staff have been advised of the expectation for clear written rationale in circumstances where the documentation has not been completed (as highlighted under response 1 above).

Concern 4)
Mrs Beasley had been requesting an urgent appoint and responded immediately to a letter from the Trust informing her she needed an urgent psychiatric appointment. When Mrs Beasley contacted the crisis team, she was again informed incorrectly that she had recently had a V4 psychiatric assessment and did not require an urgent appointment.

Response:
We refer to the reply set out under concern 1 above. Additionally, by way of assurance, the Trust handover protocols are now more robust and are carried out electronically using a rolling

document with detail about patient's presentation, action points for carry over to next shift and any emerging risk factors. This electronic record can be accessed by all crisis staff.

Psychiatrist review requests are now all sent to an MDT email address rather than to individual psychiatrists, so that this may be actively, and in a timely way attended to by the MDT review. The team is now supported by three senior leads within the team.

Concern 5)
Multiple experienced members of the mental health teams had contact with Mrs Beasley between January and March and did not make detailed entries into the medical ? or ask questions of Mrs Beasley about what additional information she had to provide about her risks of harm and suicidal ideation, review of her medication given her deteriorating mental health and calls to the crisis team disclosing increasing suicidal thoughts and ideation accompanied by acts and plans. There was a lack of professional curiosity and poor record keeping and rationale for decision-making.

Response:
The Trust has put in place 'STORM' training which is a three day training package that encompasses best practice, research, evidence, and lived experience in self-harm and suicide prevention and related fields. The benefits of this training include:

- Developing and enhancing skills
- Improving attitudes
- Increasing confidence in helping someone who is in distress

This training is offered to all registered clinicians across our urgent care pathway and we have a case for change developed through our trust wide suicide prevention group focussed on widening this to all registered clinicians cross the whole Trust. The case for change also details EPUTs plan to move away from risk stratification to align with latest NHSE guidance 'staying safe from suicide' published in April 2025.

As part of our trust year 1 priorities for suicide prevention we set a target of 50% by April 2025 of registered urgent care practitioners completing the 3 day training, this was achieved. Compliance in June 2025 reported an increase to 73% compliance of training attendance in this area against a target of 95% to be achieved by April 2026. The Trust's plan to achieve full compliance includes an increase of Trust facilitators training. A further 8 facilitators commence in September 2025, increase training capacity

I hope that I have provided some reassurances around the steps that we have taken to address the issues of concern contained within your report. We know there is an acute need to embed and effect change, hence we will monitor the above provisions to ensure these are contributing to our overall aim of keeping patents safe and delivering therapeutic care.

Please do let me know if you require any further information at this stage.

We understand that a copy of this reply will be shared with the family.

Yours sincerely,

[redacted]

Chief Executive