Essex County Council
Adult Social Care
PO Box 11, County Hall
Chelmsford
Essex CM1 1LX

Essex County Council

Private and Confidential

03 December 2025

HM Area Coroner, Ms Sonia Hayes
Seax House
Victoria Road South
Chelmsford
CM1 1QH

[redacted]

Dear Ms Sonia Hayes, HM Area Coroner,

Thank you for your Regulation 28 report regarding the death of Mrs Jill Steedman addressed to Essex County Council's Chief Executive. I am responding on their behalf as Director for Adult Social Care South, Basildon and Brentwood.

I know you will share a copy of this response with Mrs Steedman's family and I would first like to express my condolences. Every death of a vulnerable person by suicide is a tragedy and the safety of those we support is our absolute priority.

You have expressed concern related to the care and support provided by Essex County Council's Adult Social Care service. Before addressing the areas you have raised in the PFD I think it may be useful to note that the provision of support for those with mental health needs involves several public bodies employing skilled professionals who together provide the multi-disciplinary care and support the person, and their family, requires.

It may also be helpful to set out the responsibilities of Essex County Council's Adult Social Care service in this case. Our involvement was limited to participating in the production of the S117 aftercare plan in line with our responsibilities under the Mental Health Act 1983, which covers the care and support required to minimise the risk of readmission to hospital, and to additionally consider any further needs in line with our duties under the Care Act 2014 and to meet any needs found to be eligible.

We accept the recommendations made in the Prevention of Future Deaths Notice as they relate to Essex County Council's Adult Social Care service. We are committed to learning the lessons from this tragic case and delivering the necessary reforms to ensure that vulnerable people are as safe as possible.

In this case, it is clear there were failures of communication and coordination between system partners that resulted in missed opportunities to fully review Mrs Steedman's support and risk assessment following her discharge from hospital.

We have been working to address the failings identified in this PFD. Some of this work has been internal, by reviewing our own policy and processes, and some with system partners such as Essex Partnership University NHS Foundation Trust (EPUT).

To ensure roles and responsibilities for investigating deaths are clear we have been working with our colleagues in EPUT to ensure that their Patient Safety Incident Response Framework (PSIRF) is robust. We have met with the EPUT lead in this area and have provided detailed comments on their PSIRF to ensure that safeguarding remains at the centre of the approach, patient safety investigations are appropriately dealt with, and, where Adult Social Care needs to be involved, we are engaged at the earliest opportunity. We will continue to work with EPUT as they further develop their PSIRF.

We have also been working with system partners to improve the governance arrangements that support mental health care in our administrative area and are presently working on a revision to the Section 117 policy to ensure that it supports the effective delivery of care in this important area and incorporates the learning from Mrs Steedman's sad death. This work is ongoing, but we anticipate it will be completed within the next six months.

Critically the findings in this case, and in particular the recommendations set out in the PFD notice, have identified the need for us to take a detailed look at the operational delivery of care and support in this area. We have already started work by reviewing our policies associated with the delivery of our Mental Health Act obligations and are currently examining the operational configuration of our own Approved Mental Health Professional service, but we need to do more.

In response to this PFD, we will undertake a full review of our community mental health social work arrangements, including the existing arrangements supporting joint working, to ensure roles and responsibilities are clear. We expect this work to take place over the next year and we are committed to ensuring that the outcome of this work is safer with better coordinated support for those using the service.

I hope this response provides reassurance that we do take your concerns seriously and will act on them. Mrs Steedman's death was a tragedy for her family and all those who knew and loved her, and we are committed to doing all we can to learn from her death.

Yours Sincerely,

Director for Adult Social Care South, Basildon and Brentwood