Essex Partnership University
NHS Foundation Trust

03 December 2025

Chief Executive Office
The Lodge
Lodge Approach
Wickford
Essex
SS11 7XX

[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,

Jillian Anne Steedman (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 10th October 2025 in respect of the above, which was issued to Essex Partnership University NHS Foundation Trust (EPUT) and Essex County Council following the inquest into the death of Mrs Steedman (RIP).

I would like to begin by extending my deepest condolences to Mrs Steedman'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 the concerns relating to EPUT in the hope that this provides both yourself and Mrs Steedman's family with comprehensive assurances of the changes that have been made at the Trust to address the concerns you have raised.

Concern 1) There was a lack of information sharing between professionals involved in the care and treatment of Mrs Steedman who was a complex mental health patient with a long history of treatment resistant mental disorder.

Response:
The Trust appreciates the need to ensure information sharing between professionals is carried out in a robust and timely manner. To share the learning on this point, a post-Inquest debrief was held with the Community and the Crisis Response Team teams to discuss the Inquest and the concerns raised with regards to information sharing.

We recognise the need for a structured approach in addressing the lack of information sharing between professionals caring for a complex mental health patient. The Trust has identified in Mrs Steedman's case that the root causes included systemic barriers of incompatible electronic health record systems, cultural issues with professional silos, and process gaps in communication during her transitions of care.

We have strengthened our governance by reviewing our information-sharing protocols with specific reference to how we work with professionals in other organisations. We have introduced structured communication methods for handovers and shared care plans which we have made accessible to all involved professionals including care home and social care staff. We are working in a more collaborative culture through regular multidisciplinary team meetings which is supporting our patient's safety and planning. The Trust has relooked at its named

worker roles and responsibilities to ensure accountability and uses audits to monitor compliance.

Finally, we are continuing to involve patients and families by managing consent proactively and documenting preferences through advance statements throughout the patient's journey.

Concern 2) Mrs Steedman's consultant responsible for ongoing Electroconvulsive Therapy (ECT) was not informed of her mental health deterioration. Previous adjustments to the frequency of ECT had proved beneficial.

Response:
Changes in a patient's condition is discussed within the MDT and this is communicated to all relevant parties who play a valuable role in supporting patients and their families. Records on MDT meetings are inputted onto the electronic patient record (EPR) allowing for these to be viewed by all interested parties

Concern 3) There was a dispute in evidence between the mental health Trust care co-ordinator and other witnesses that this was a complex case with a complex discharge. Mrs Steedman had experienced a failed, and several delayed discharges due to the complexity of her case.

Response:
The Trust MDT collectively agreed that Mrs Steedman's case was a complex case, this was evidenced through different witness statements during the Inquest. All clinical staff will have their own clinical judgement on a case based on experience and expertise, however the role of the MDT is to ensure there is a collective approach to, and understanding to, the purpose of supporting patients and their families. This would also be true for bank and agency staff. For all staff this is monitored through good supervision, agency, and audit compliance. one of the objectives of the MDT meetings is to discuss each case and develop a collective view to aid safe and efficient care.

Concern 4) The mental health Trust staff involved in the discharge and community care of Mrs Steedman were put on notice by a clinical lead on 16 March 2023 that the care plans, risk assessment and procedures relevant to the discharge had not been completed and were required in addition to the integrated plan that was attached to the email. These were never completed.

Response:
Since Mrs Steedman's death, the importance of recording information in the care-plan section has been addressed. This has included discussing in meetings with staff, supervision and audit.

Concern 5) Mrs Steedman was discharged to the care home on 11 April 2023 from mental health hospital following an admission of over 12 months and previously failed discharges. Evidence was heard Mrs Steedman was not appropriately placed in the Care Home based on her needs and the local authority were on notice that another care home had refused to admit Mrs Steedman due to her mental health. There was no review and the s117 care plan had not been updated since 13 September 2022

Response: This concern is for Essex County Council (ECC) to respond to.

Concern 6) The mental health Trust staff and the local authority social worker were visiting Ms Steedman. The integrated plan required significant visits for Mrs Steedman initially every day with out of hours support available with a slow taper off over weeks. None of the visiting professionals asked to review the care plans or risk assessments and any such scrutiny would have revealed these necessary documents had not been completed.

Response:
We refer to our reply above under concern 4 in respect of care plans and risk assessments. In addition, as part of team reflections in this matter, the importance of professional curiosity was discussed and the team were reminded that they should review care home paperwork (where access is possible) and also speak with carers within the home. Support sessions were provided on asking right questions using professional curiosity and how this would have given more opportunity to understand Mrs Steedman's needs and risks, whilst acknowledging that the Care Home may in turn approach the Trust with regards to any information or support required.

Concern 7) Visiting Professionals did not complete the required reviews necessary when Mrs Steedman was distressed and experiencing crises.

Response
The Trust has shared learning through the lessons team available to all clinical and non clinical staff. Information regarding patient care is discussed robustly through MDT's and supervision, Caseloads are reviewed through audit.

Concern 8) The appropriateness of the placement was not reviewed following a crisis on 15 April 2023 just a few days after admission.

Response: This concern is for ECC to respond to.

Concern 9) Mental health resource 'Sanctuary' became involved in supporting Mrs Steedman as a consequence of the handling of the call to the crisis team, this was not part of the Integrated Plan and should have raised concerns when entries appeared in the mental health records that this crisis had not been actioned with the appointed support teams involved.

Response
In this case the CRS assessed the needs of Mrs Steedman and identified that she needed support over the weekend. They were aware she was open to community services. The decision was taken to seek support from Sanctuary who were able to provide non-clinical support, thereby providing Mrs Steedman with another layer of support. There is now a multi agency Transfer of Care hub where any patient who has had contact with the Urgent Care Pathway will be discussed and a follow up action attributed.

Concern 10) The Trust investigation following Mrs Steedman's death did not:

a. Refer to any delay in the Trust completing the risk assessment or the omission of the agreed risk management for Mrs Steedman following the professionals meeting on 27th April 2023. The Care Home raised concerns with the Trust that Mrs Steedman had ongoing expressed suicidal risk and that she was travelling unaccompanied and may divert the taxi. Mrs Steedman had gone for a home visit that morning and due to the risk, the Care Home Management had directed Mrs Steedman be accompanied by a member of care home staff. The Care Home Management were directed by the mental health Trust team that they must not interfere with the Integrated plan and that Mrs Steedman must not be accompanied. It was agreed that a risk assessment and risk management plan would be completed by the mental health Trust and provided to the Care Home. This had not been received by 5 May 2023 and the Care Home drafted its own risk assessment.

b. Note significant deficiencies in the mental health Trust risk assessment completed and sent to the Care Home later on 5 May 2023 that made no reference to:

c. Contact with the Trust Crisis Team on 15 April 2023 where Mrs Steedman was expressing suicidal thoughts and that she would throw herself in front of a train.

d. Concerns raised by the care home that Mrs Steedman was expressing ongoing suicidal thoughts and may divert the taxi to the train station.

e. Assessment of the current risk Mrs Steedman would harm herself by throwing herself in front of a train, the likelihood of the risk occurring and that the outcome would be fatal.

f. Assessment of the specific risk of Mrs Steedman taking a taxi home and may divert the taxi to the train station raised by the Care Home Management.

g. The absence of a Trust risk management plan to manage Mrs Steedman going home alone in a taxi and there was a lack of understanding that Mrs Steedman was paying the taxi driver in cash.

h. Delay in the attendance of the mental health Trust team following concerns raised by a Trust health care assessment that Mrs Steedman was experiencing a crisis, was expressing suicidal thoughts and was so distressed she could not stand up on 10 May 2023. The FIRST team had seen Mrs Steedman that morning as part of a planned visit to support out of hours and had made entries in the medical records with no significant concerns at that time. Evidence was that the FIRST team were not informed of the crisis, should have been and were available and would have attended the same day. This was part of the integrated plan and this was not actioned. Instead, a decision was made for attendance of the community older adults' team the next day leaving Mrs Steedman in distress.

i. Mrs Steedman was in significant distress on the visit on 11 May 2023 and the mental health nurse was unable to complete an assessment, did not alert the FIRST team for assistance and left Mrs Steedman in the care home in the care of staff with no mental health expertise.

j. Note that a risk assessment following the visit on 11 May 2023 was entered into the medical records on 12 May 2023 after Mrs Steedman had died. This was not entered into the record as a retrospective entry and the medical record was accessed after Mrs Steedman's death.

Response

There is an important need to afford impartiality to the author / the family in respect of such reports in relation to agreed Terms of Reference (TOR). The internal report is prepared for learning purposes, with the TORs being agreed with families in advance (where they wish to engage with the investigation process). This then sets the framework of the review. It would be inappropriate for this framework to be influenced by any other process, in terms of what should or should not be covered within the investigation.

Work is ongoing to increase the robustness of the patient safety incident reports, particularly around the setting of Terms of Reference which set the focus for the review. The Care Unit Incident Review Group and the establishment of the Patient Safety Lead role within the care unit has strengthened this process during 2025.

There has been joint work between EPUT and ECC that has led to an improvement in joint working on patients safety investigations, and this is also reflected in the updated PSIRF Policy

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, including copies of any of the documents referred to above.

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

Yours sincerely

Chief Executive