Essex Partnership University
NHS Foundation Trust

27 March 2026

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

[redacted]

**Private and Confidential**
Mr Sean Horstead
HM Area Coroner
Coroner's Court
Seax House
Victoria Road South
Chelmsford
CM1 1QH

Dear Sir,

**Mr Stuart Christopher James Berry (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 12th January 2026 in respect of the above, issued to the Trust, the Ministry of Justice, HM Prison and Probation Service and HCRG following the inquest into the sad death of Mr Berry.

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

This letter sets out Essex Partnership University NHS Foundation Trust's formal response to your Regulation 28 report of 12 January 2026.

We have carefully considered the concerns you raised and, where they relate to EPUT, we describe below the actions taken and the further improvements underway. For completeness, Appendix 1 summarises:

(1) relevant PFDs received, (2) assurances provided, and (3) implementation of changes.

**National Policy Context – The Changing Role of the "Care Coordinator" AND System Responsibility**

We note your concerns about the performance of the Community Mental Health Team (CMHT) and the allocated Care Coordinator (CC). We fully acknowledge the importance of robust care planning, risk assessment, documentation, and integrated working. We would also respectfully place these issues within the nationally recognised transition away from the historic Care Programme Approach (CPA) care coordinator model toward team-based, place-based, multidisciplinary models of care:

- NHS England's Community Mental Health Framework (2019) explicitly set the direction for replacing CPA for community services, retaining its principles (good coordination and care planning) while shifting to a whole-person, whole-system approach delivered by multidisciplinary teams and partners.
- NHS England's CPA Position Statement (v2.0, 1 March 2022) confirms that the Community Mental Health Framework has superseded CPA, encouraging systems to move away from the single CC/CPA construct and embed a broader team-based model and universal standard of high-quality care planning.

In practical terms, these national policies recognise that in today's complex system, it is not realistic or safe to expect one individual (the CC) to carry the full responsibility for system integration, multi-agency coordination and continuous risk oversight. The drive is to organise care around MDTs, shared pathways, and integrated hubs, with clear escalation routes and shared accountability, rather than reliance on a single practitioner.

Health systems across England are implementing this change to move away from CPA within a hub-based model, underlining that this is a national transition, not an EPUT-specific issue. A 2026 peer-review analysis of 586 health related PFD reports (2013-2025) found that coroners increasingly identify inter-agency coordination, care planning, risk and safety management and hand overs as key factors in death.

The study reports that concerns have shifted over time from access and resources toward joint working failures, record keeping, and risk assessment, all issues directly tied to traditional CPA/care coordination functions. These themes mirror the issues raised in Mr Berry's case.

In March, the Executive Chief Nurse, Transformation Lead, and Director for Community Services in NE Essex met with NHS England to further explore the national direction and forthcoming guidance relating to community mental health transformation. At present, there remains limited clarity from NHSE, and as a result EPUT is working closely with regional colleagues to navigate this transition safely, pragmatically, and in a way that preserves meaning and clinical integrity. This shift will require significant cultural change both within the organisation and across our wider system partners, as expectations around care planning, personalised care, and shared responsibility continue to evolve.

To support this work, Community First engagement events have been held with key stakeholders across both North and South Essex in February 2026**.** These events have been essential in fostering open dialogue, strengthening joint understanding, and enabling genuine system collaboration as we move towards more integrated models of community mental health care. This partnership-based approach is central to ensuring that changes to practice, documentation, and communication processes are not only operationally feasible but also aligned with the realities faced by our frontline staff and external agencies.

This partnership approach is grounded in developing an authentic, trusting relationship with our Lived Experience Ambassadors**,** who play a central role in the redesign of services and in redefining the roles and responsibilities of all stakeholders, including the person and their wider community. Their involvement has been essential in shaping a more meaningful, person-centred model of community mental health care.

We have now reached a stage where our Lived Experience Ambassadors have worked alongside us throughout this journey and are actively supporting the recommendations for the Complex Needs Pathway within community mental health services—an area that would traditionally have been managed under the CPA framework. The development of this pathway has taken place over a longitudinal period at the request of our Lived Experience Ambassadors, who have been clear that accelerating the process or imposing a model prematurely would risk repeating longstanding challenges experienced nationally and locally. They have emphasised that a genuine co-produced approach requires time, reflection, and psychological safety.

We have respected this position and consciously worked at a pace that maintains psychological safety, supports genuine collaboration, and avoids replicating historic patterns of rushed or top-down change. We acknowledge that the length of time required to co-produce these new models may be frustrating from an external perspective, including for

the Coroner. However, sustainable change cannot be achieved overnight. For these pathways to be effective, credible, and meaningful for the communities we serve, the roles, responsibilities, and expectations within them must be carefully developed, supported, and embedded.

Aligned to this, the Patient Safety Incident Response Framework (PSIRF) requires the NHS to adopt a systems-based approach to safety—understanding contributory factors across teams, workflows and environments, and moving beyond a purely individualised lens when learning from incidents.

Finally, with regard to governance expectations, CQC Regulation 17 (Good Governance**)** requires effective assurance and auditing systems or processes to monitor and improve quality and safety; it does not prescribe that every single care plan or case be audited, but expects proportionate systems that assess, monitor and mitigate risk and drive improvement.

We offer this context not to diminish the seriousness of the failings identified in Mr Berry's case, but to explain the nationally endorsed direction of travel and the structural changes we have been implementing locally to reduce the likelihood of recurrence.

The Regulation 28 Report issued following Mr Berry's death raises a number of concerns which we address as follows -

**(a) Performance of the CMHT and the allocated Care Coordinator (under CPA/EPUT policy)**
EPUT maintains a governance framework that includes regular clinical supervision, weekly MDT forums, escalation procedures, and **c**ase auditing to identify and address gaps. We recognise the expectation that staff practise in line with Trust policy.
Trust-wide audit requirements were reviewed in January 2026. While the final Trust standard is being confirmed through the Community First Project, our interim approach combines:

- **Local, bi-monthly sample audits** in certain localities (e.g., 5 cases per practitioner every two months), and
- **Themed Trust-wide sampling**, with the next cycle scheduled March 2026 (targeted sample across teams to test compliance and learning themes).

This sample-based method is proportionate to caseload size, supports thematic learning, and is consistent with Regulation 17 expectations for effective, risk-based assurance rather than exhaustive case-by-case auditing.

Audit results are shared through local governance structures to ensure learning is shared. Supervisors use MaST (Management and Supervision Tool) and monthly performance reporting to monitor documentation timeliness and CPA/care-planning activity, with targeted follow-up where deficits are identified. The mandatory use of MaST was implemented in January 2025. In the Thurrock community team, auditing of case loads were commenced in June 2025 and case load issues were noted in the 6-to-8-week supervision requirement. EPUT`s Community First project will clarify the frequency of auditing required as MaST only identifies that documentation is in place and not the contents and quality.

Thurrock has an assigned lead who has been tasked to carry out 5 such audits for each staff member every 2 months. This process has been intermittent due to available resource, and the Trust has re-enforced the importance of these audits with the next audit due to be carried out in the month of March 2026.

Similar audit processes are already in place in other community mental health teams across EPUT, though with slight variations in who carries them out. Work is currently underway to

standardise this approach, with community services being the first area to adopt the unified approach.

This sample-based method is proportionate to the size of our commissioned workforce and reflects established custom and practice across community mental health services nationally.
Given the scale and complexity of community caseloads, it is not operationally feasible nor required to monitor all cases individually.

National audit examples in social care similarly use sample-based caseload audits as part of their quality assurance frameworks.

**b. Failures in Care Planning**
In reviewing Mr Berry's case, there is no evidence to suggest a systemic organisational failure. The required systems, governance structures, and escalation processes were in place and functioning. The concerns identified relate to professional practice**,** rather than a failure of the systems themselves.

Mr Berry had been known to the Team for just over three months. During this period, the Management and Supervision Tool (MaST) showed that documentation was in date. However, MaST only identifies whether Care Plans or reviews meet the mandated six-monthly cycle. It does not analyse the content of those documents and therefore cannot detect when a review should be completed earlier due to a change in clinical risk. Identifying such changes and initiating an out-of-cycle update remains a core clinician responsibility.

Supervision took place, and no acute concerns were raised by the Care Coordinator. Staff were also routinely reminded to use the weekly MDT to escalate any emerging risk. Despite these available mechanisms, Mr Berry's case was not brought forward.

It is important to recognise the complexity of the Care Coordinator role within community mental health systems. Care Coordinators manage high caseloads, navigate multiple systems, and hold significant clinical responsibilities. This level of complexity can sometimes affect consistent completion of all required tasks, particularly in a system undergoing transformation toward more distributed, multidisciplinary models of care. This is one of the reasons the Trust has been shifting away from models where a single Care Coordinator is responsible for every aspect of a service user's care.

As part of strengthening practice, EPUT has developed a Care Planning Training Package, initially piloted in North East Essex and reviewed across the EPUT-wide safeguarding forums during 2024/25. The pilot was complex, partly due to delays in the release of updated national CPA guidance from NHS England. In response, EPUT adopted a pragmatic interim approach, embedding the updated care planning principles into a holding training package. This approach has been agreed collaboratively with regional colleagues through NHS England forums to ensure best practice while awaiting the final national framework.

This Care Planning Training is now a mandated requirement for all community staff and roll out began in February 2026. It has been rolled out across the organisation, targeting community and primary care services. The programme provides clinicians with a framework underpinning safe and effective care planning, including:

- core principles of community mental health practice,
- expectations around clinical governance and risk management,
- the responsibilities associated with timely documentation and escalation,
- best practice guidance,
- case studies, learning themes, and clinician reflection.

During the period in question, the following governance structures were in place within the Team:

- regular supervision,
- weekly MDT forums for escalation,
- MaST oversight of CPA compliance, and
- reintroduced local audits.

Given the size of the caseload—approximately 380 patients—it is neither operationally feasible nor supported by existing resources for senior staff to proactively review every case in detail. The system therefore relies on clinicians applying sound judgement, using supervision effectively, and escalating concerns appropriately through MDT structures. These processes were available, embedded, and repeatedly communicated. In Mr Berry's case, they were not utilised as required, and the necessary out-of-cycle CPA update following a change in risk did not take place. This represents a professional practice failure**,** not a failure of organisational systems.

The practitioner involved is currently subject to the Trust's capability process. To complement formal training, EPUT is in the process of introducing a Care Coordination Competency Framework for all new starters. This framework will sit alongside the valued and essential *on-the-job learning* already provided within teams and will form a core component of each new staff member's probationary period**.**

This ensures that new colleagues not only receive structured learning but can also evidence their skills, knowledge, and decision-making in practice. In parallel with the interim Care Planning Training Package, the Trust has been contributing to the development of a new Care Planning Framework, which is currently in the final stages of review. The full organisational roll-out is scheduled to commence in Summer 2026. This framework is intentionally aligned with the national shift away from the traditional CPA model and towards a more personalised care agenda. As such, significant time and collaboration have been invested to ensure that the framework is authentic, meaningful, and genuinely reflective of modern person-centred practice, rather than creating a task-based or overly procedural approach to competencies.

This deliberate development approach is essential to ensure that personalised care is embedded in a way that strengthens clinical practice, supports professional judgement, and improves service user experience. The Trust has been clear that it did not want to adopt a checklist-driven model but instead wanted a framework that supports thoughtful, relational, and safe care planning that distributes responsibility across the multidisciplinary team. addition, the Trust are piloting a scheme in which "care coordination" staff undertake a structured self-evaluation against the competency framework, supporting a systematic assessment of their development needs.

The next scheduled session within this pilot is taking place on 09 March 2026 in Mid Essex**.** This process will directly inform each staff member's individualised training plan for the following two years and ensure we continue to strengthen the skills, capabilities, and confidence of our existing workforce.

This enhanced emphasis on competencies, reflective learning, and ongoing development forms a key component of the Trust's wider approach to improving safety and quality of care. It aligns closely with the PSIRF emphasis on human factors, team capability, and system-level learning**,** moving beyond reliance on audits or isolated changes to documentation. By supporting staff to critically appraise their practice, identify developmental needs, and engage in structured learning pathways, the Trust is working to build a more resilient, skilled, and confident workforce—one better equipped to meet the needs of service users in complex community settings.

**c and d. Failures in Risk Assessment and Documentation**
EPUT recognises that failure to document in line with quality standards and clinical guidelines can pose risks to continuity of care, clinical decision-making, and patient safety. To understand the underlying factors that influence staff's ability to document to the standard they aspire to, the Trust has undertaken a number of targeted pieces of work.

This has included hosting two large engagement events with Care Coordinators from across all areas of Essex, enabling the organisation to gather direct feedback and identify common themes affecting documentation quality, workload management, and pressures within the role. A consistent and strongly expressed theme from the community workforce has been frustration about the need to balance documentation requirements with spending meaningful time with patients and their families**.** Staff reported that, although they fully recognise the importance of high-quality documentation, the competing demand between administrative requirements and relational, patient-facing work remains a significant challenge.

Alongside staff engagement, two "Patient Experience: Real Versus Imagined" workshops were held in November 2024 and October 2025**,** exploring how documentation, communication, and care planning are perceived by service users. These sessions aimed to ensure that improvements in documentation also translate into improved lived experience, supporting a more personalised and relational approach to care.

In March 2026**,** the Trust also hosted a Safety Improvement Programme Workshop**,** bringing together leads from all ongoing safety improvement initiatives. The purpose was to cross-reference learning across programmes, ensure alignment with PSIRF principles, and examine how safety improvement activities interface with the actual day-to-day challenges faced by Care Coordinators—including those relating to documentation burden, system navigation, and competing priorities.

Collectively, these activities reflect the Trust's commitment to understanding the human, systemic, and environmental factors that impact staff practice. This work supports the wider organisational shift toward a PSIRF-aligned approach that prioritises continual learning, capability building, and system-level improvement—not simply process compliance or changes to forms.

To further support sustainable improvements in documentation quality and workflow, EPUT is reviewing the need for an interim post dedicated to assisting with documentation and workflow management ahead of the planned implementation of NOVA**,** the Trust's new electronic patient record (EPR) system.

Once implemented, NOVA will enable real-time documentation**,** supported by improved task management functions and the ability to auto-populate forms using information already recorded elsewhere in the system. This functionality is expected to significantly reduce administrative duplication, improve accuracy, and free up more staff time for direct clinical work with patients and families.

Until NOVA is fully operational, EPUT continues to maintain robust interim monitoring arrangements to support safe and timely documentation. Alongside this, the Trust is currently reviewing the requirements for personalised care planning and safety planning documentatio**n**, with the aim of determining whether the existing EPR can accommodate a single, consolidated place for recording and update associate standard operating procedures**.** This work is intended to reduce the burden associated with navigating multiple tabs and scattered documentation fields, making it easier for clinicians to record care consistently and for teams to access essential information quickly.

These developments sit alongside the broader organisational work to strengthen competencies, reduce unnecessary administrative load, and ensure that clinical documentation supports both personalised care and safer decision-making.

As set out in our earlier response to the Prevention of Future Deaths report, we continue to monitor adherence to the 95% target for clinical documentation to be completed within 24–48 hours of patient contact. This is overseen through a combination of:

- Caseload reviews within line-management supervision, where documentation quality, timeliness, and risk-related entries form a routine part of the discussion.
- Monthly performance reports, which provide clear visibility of each clinician's activity, including any incomplete or overdue documentation. Where gaps are identified, managers hold individual discussions with staff to ensure timely completion and address any underlying issues impacting their ability to meet required standards.

These measures demonstrate that monitoring and governance systems remain firmly in place, consistent with the expectations previously outlined following the case of Robert Moore (February 2022).

They also strive to ensure that any risks associated with delays or omissions in record-keeping are identified and acted upon promptly while we transition toward a more modern, streamlined digital system under NOVA.

EPUT maintains systematic performance monitoring and governance oversight, which is formally reviewed each month through established reporting structures.

Performance, quality, risk, and safety indicators are presented to the Executive Team and Senior Leadership Team, ensuring a clear and consistent feed-up, feed-down governance approach. This process is embedded within our internal Accountability Framework, which was developed as part of our wider quality-improvement and patient-safety programmes.

The framework enables operational issues, risks, themes, and areas of concern to be escalated appropriately, while ensuring that learning, expectations, and quality standards are communicated consistently back to operational teams. This ensures that leaders at every level have visibility of performance, and that staff receive the guidance, feedback, and support required to maintain safe, high-quality care.
As previously outlined, the Team has established systems in place to monitor compliance, including the use of the MaST (Management and Supervision Tool) in staff supervision and oversight against the monthly Performance Reports. These tools have been used actively since 2024 and provide assurance that reviews are in date against the mandated six-monthly cycle, while also highlighting when documentation is overdue.

However, as noted earlier, MaST only identifies whether documentation is up to date within the required six-monthly timeframe. It does not analyse the content of those documents and therefore cannot detect when a document requires updating outside the routine cycle due to a change in clinical risk. This responsibility remains with the clinician.

In Mr Berry's case, he had been with the Team for just over three months, and MaST correctly showed the documentation as in date. However, the required out-of-cycle update following a change in risk did not occur, and the case was not raised through supervision or MDT structures. This reflects a professional practice issue, not a failure of the monitoring systems previously described.

**e and f. Failures in Joint Working**

Thank you for highlighting the concerns regarding joint working in this case. I acknowledge the coroner's observations and set out below our response in relation to the identified failures and the steps we have taken to ensure improvement.

**e. Failure in Joint Working Internally**
We recognise that the Care Coordinator did not escalate concerns or seek consultation with colleagues through our established internal pathways, including the weekly Multidisciplinary Team (MDT) meeting or alternative professional forums. These structures exist precisely to support shared clinical decision-making, risk formulation and case escalation, and the failure to utilise them represented a missed opportunity to review the patient's presentation collaboratively.

Since the incident, we have introduced measures to support staff in consistently meeting expectations around escalation and collaborative working. We recognise that embedding these behaviours is a gradual process and requires ongoing reinforcement, supervision and oversight, which we will continue to prioritise through:

- Strengthened escalation expectations: Clear guidance has been reissued to all staff outlining mandatory escalation routes when risk indicators change or when there is clinical uncertainty. This is evidenced via the introduction of an MDT Agenda, which ensures that governance around this important area is kept under review. To provide an example, the Thurrock Team have developed a weekly MDT agenda which is circulated ahead of the MDT to all staff to ensure all staff are reminded of high-risk cases to discuss. A copy of one such agenda is attached, together with case presentation templates as reviewed in September 2025.

- MDT attendance and oversight: All teams are now required to document which cases need MDT discussion, with team leaders reviewing compliance weekly.

Training and supervision improvements: Care Coordinators are receiving targeted training on recognising complexity and the thresholds for escalation, supported through reflective, restorative supervision. This was rolled out in 2024. Monthly CPD review sessions are in place for staff (these have been in place since beginning of 2025) which incorporate elements of restorative supervision, as appropriate. Staff 1:1 and staff mediation sessions also remain in place.

The roll-out of restorative supervision across our community teams will further strengthen our internal measures. Evidence from both national and local implementation shows that restorative supervision reduces staff stress and burnout, improves wellbeing, increases compassion and professional resilience, and supports more effective decision-making. It also enhances staff's emotional capacity to engage constructively with other professionals, enables them to better understand and maintain healthy boundaries at work, and contributes to a calmer, more reflective workforce.

As these benefits embed over time, we expect restorative supervision to improve staff ability to make full and effective use of the systems already in place, and to support stronger team functioning and more consistent multi-agency working.

Significant changes to the Dual Diagnosis pathway will support a reduction in 'refer-on' practices and minimise the passing of individuals between teams.

Under the revised Essex County Council model, Care Coordinators will be trained to support dual diagnosis needs within their own clinical practice, with access to trained Dual Diagnosis Ambassadors embedded in each team. This represents a deliberate shift away from a traditional referral-based approach, which is inherently limited by the receiving team's

capacity to accept and act on referrals—particularly in the context of ongoing reductions in funding. Instead, the Trust has moved towards a model in which dual diagnosis is recognised as everyone's business. This approach is now embedded across community teams and reflects the expectation that all staff have the capability to identify and respond to co-occurring mental health and substance misuse needs as part of routine practice.

The intention behind this shift is to ensure that dual-diagnosis issues are addressed earlier, more consistently, and within the patient's existing therapeutic relationships, rather than relying on transfer to a separate team. This supports better continuity of care and strengthens multi-agency collaboration, while also making more effective use of the internal expertise available within multidisciplinary teams.

We are confident that these measures will support more consistent use of MDT processes, enhance internal consultation pathways, and improve the quality and timeliness of intervention for individuals with co-occurring needs. In addition, across our South Essex localities we have implemented a Mental Health Transfer of Care Hub (MH TOCH) as part of our approach to ensuring safe and coordinated follow-up for individuals who have recently had contact with local crisis services. The MH TOCH model was introduced in February 2024 in Basildon, September 2024 in Southend, and December 2024 in Thurrock. Meetings are held three times per week and provide senior oversight from Team Leads and Managers to ensure that all patients who have accessed crisis services receive an appropriate and timely follow-up plan.

Where an individual is already under Care Coordination, the representative from the Community Mental Health Team will take forward the required actions and ensure that the allocated worker undertakes a review of the person's needs, risk, and management plan. All discussions held within the MH TOCH are recorded directly in the person's electronic record to support continuity, transparency, and clinical accountability.

Similar meetings take place in other areas of the Trust; however, the terminology and structure vary. As part of the Community First standardisation programme, we are currently working to align the naming, format, and core functions of these meetings across all localities to ensure consistency, equity of practice, and clearer organisational expectations.

**Failure of Joint Working Externally (concern f)**

In parallel, we are expanding the rollout of STORM training, which has been successfully embedded within Crisis Teams, into our Community Mental Health Teams. This training supports high-quality, evidence-based assessment, safety planning, and risk documentation—all of which are critical components of safe community mental health practice. These capabilities are also essential for effective internal and external joint working, ensuring that when multiple agencies are involved in a person's care, information is clear, risk is articulated consistently, and actions are well-coordinated. High-quality documentation and shared understanding of risk enable safer handovers with partners such as primary care, crisis services, social care, ambulance services, and police, and they support more timely and informed decision-making across agencies.

Collectively, these initiatives form part of a broader organisational commitment to strengthening documentation standards through system-level improvements, better-aligned workforce support, and reductions in unnecessary administrative burden. This approach allows staff to engage more effectively with external partners and maintain safer multi-agency coordination, rather than relying solely on audit processes or adjustments to paperwork.

EPUT recognises that developing meaningful and sustainable community-thematic learning is a journey rather than an immediate outcome.

This work must progress alongside the realities of demanding caseloads, operational pressures, and the complex human factors that shape practice in community mental health settings. While we have implemented all appropriate actions and assurances arising out of Coronial proceedings with integrity and urgency, we are also aware that lasting change cannot be achieved overnight**.** Rapid, surface-level change risks being unsustainable; our focus is instead on creating the conditions for deep, cultural improvement in the way staff are supported, supervised, and equipped to learn from incidents.

**Failure in Communication (concern g)**

EPUT recognises that failures in communication—whether in escalating concerns, documenting changes in risk, or sharing vital information across teams—can significantly compromise patient safety. To address this, the Trust is shifting towards a more holistic approach to staff wellbeing, training, and psychological safety. Safe practice is strengthened when staff feel supported to speak up, seek help, and communicate uncertainty or concern at the earliest opportunity, rather than attempting to manage increasing pressure alone. This cultural work is fundamental to improving the consistency and reliability of documentation, clinical decision-making, and risk management, all of which depend on timely, accurate, and transparent communication.

At the same time, practitioners continue to be held to account through their professional registration. Organisational support is designed to enhance—not replace—individual responsibility for clear communication, proper documentation of risk, and use of escalation pathways.

Our aim is to build a system in which thematic learning, strong communication behaviours, staff support, and professional accountability operate together. This balanced approach provides the best foundation for sustained improvement in community mental health practice, rather than relying on short-term corrective actions that fail to address the deeper human and systemic factors contributing to communication breakdowns.

Despite extensive work to strengthen learning from deaths and improve the reliability of care planning and risk processes, we recognise that lasting improvement cannot be achieved solely through changes to forms or systems. Communication failures often stem from human factors, workload pressures, and the complex realities of community mental health work. This reinforces the need for a proactive, supportive, and system-wide approach that mirrors national expectations: that the safety and quality of community mental health services are best improved through continuous learning, psychologically safe environments, effective supervision, and whole-team safety thinking, rather than through narrow corrective actions following individual incidents.

To that end, our PSIRF (Patient Safety Incident Response Framework) aligned approach places emphasis on understanding the broader organisational, systems and environmental factors that shape practice; supporting staff through restorative supervision; and developing the conditions for safe, reflective, and sustainable care. These priorities complement, traditional audit processes.

While we maintain proportionate, systematic auditing of a sample of cases each month, we acknowledge that audits alone cannot mitigate the full range of human and contextual factors present in community mental health work and therefore must be part of a wider learning-focused safety system.

I hope that I have provided 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 patients safe and delivering therapeutic care.

We remain fully committed to ongoing monitoring, transparent reporting, and open engagement with you and with Mr Berry's family. Should you require any further information, we will be pleased to provide it.

Yours sincerely

[redacted]

**Chief Executive**