Essex Partnership University
NHS Foundation Trust

22nd July 2026

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

**Trust Headquarters**
The Lodge
Lodge Approach
Wickford
Essex
SS11 7XX

[redacted]

Dear Ms Hayes

**Abbigail Louise Smith (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 27th May 2026.

This notice was received by the Trust on the above date, following the inquest into the sad death of Abbi.

I would like to begin by extending my deepest condolences to Abbi's family. The Trust expresses its sincere sympathies and acknowledges the profound nature of their 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 raised in the hope that this provides both yourself and Abbi's family with comprehensive assurances of the changes that have been made at the Trust to address the concerns you have raised.

**Concern 1:** Abbi spent most of her adult life in detention and Abbi was transferred to a specialist Tier 4 mental health hospital by EPUT for investigation and assessment of her diagnosis who confirmed she did not have personality disorder. Abbi was seen by very junior clinicians even though she was an extremely complex patient.

**Response:**

The Trust accepts that Abbi's history, complexity and recent specialist diagnostic review should have informed a higher level of senior clinical oversight. In retrospect, the level of consultant involvement did not adequately reflect the complexity of her presentation.

At this time Consultant caseloads within the community team at The Gables were elevated. The process for outpatient appointment allocation was on the basis of clinician availability rather than patient complexity or clinical seniority.

In response, the Trust has taken the following actions:

- The Gables community team has revised its allocation processes. Senior nursing colleagues now triage patients prior to allocation, with the Consultant holding oversight

of all clinic bookings. Allocation decisions are explicitly informed by the complexity of the patient's presentation, the experience and expertise of the proposed clinician, together with appropriate supervision support.

- To ensure consistency across wider Trust services, the requirement for Consultant oversight of psychiatry outpatient clinic allocations is being embedded across all community services.

- Senior clinical supervision and consultant support is now available to all clinicians managing complex patients.

**Concern 2)** The diagnosis of personality disorder was later reapplied to Abbi by a junior in the community with no rationale recorded and this was not noted or queried by the local community team or Consultant Psychiatrist.

**Response:**

EPUT acknowledges that following Abbi's discharge from the Tier 4 hospital, the diagnosis of personality disorder was reapplied by a junior clinician within the community team without any recorded clinical rationale.

The Trust further acknowledges that this was not identified or queried by the community team or the responsible Consultant Psychiatrist at the time. Whilst personality disorder and other psychiatric diagnoses may coexist, the Trust accepts that the rationale for reintroducing the diagnosis was not clearly documented and should have been subject to senior clinical review.

The Trust has strengthened requirements for documented clinical rationale when any diagnosis is amended or reapplied. Consultant oversight of diagnostic decisions for complex patients is an expectation within the community teams. The Community First team will further embed these expected standards structurally, by reducing Consultant caseloads and ensuring that oversight is achievable in practice.

**Concern 3)** In October 2021 Abbi suffered a deterioration in her mental health with reported non-compliance of Clozapine medication. The Consultant Psychiatrist emergency plan was not followed:

a. Short-term prescription of Diazepam to assist with an exacerbation of distressing symptoms to permit Abbi's Clozapine to be re-titrated was incorrectly continued as a permanent prescription in the absence of a medical review and this was not compliant with the NICE Guidelines.

b. Urgent follow-up required for a predicted and inevitable deterioration in the event of continued non-compliance did not take place.

c. Abbi's medical records were not updated as required; there were omissions in the significant information about Abbi's clinical condition and Abbi was not escalated back to the Consultant Psychiatrist. These matters were then not understood by the mental health professionals as Abbi continued to deteriorate and increase of Abbi Diazepam was prescribed.

**Response:**

EPUT accepts that although contact with Abbi continued the Consultant's emergency plan was only partially followed during this period.

The Consultant acted appropriately in October 2021 prescribing a carefully considered short-term bridging plan whilst awaiting Clozapine recommencement and arranging a medical review for December 2021.

However, the Trust acknowledges that Diazepam was converted from PRN to twice daily without clear documented medical authorisation and Abbi's decision to decline. Abbi had capacity at this point to make decisions in regards to her care and treatment. Clozapine recommencement, was not escalated back to the Consultant.

Following notification that Abbi had ceased taking her prescribed Clozapine, the Care Coordinator acted promptly by contacting her to assess her mental state and subsequently undertaking further reviews, including a home visit to discuss her wellbeing, treatment plan and medication adherence. Throughout these contacts, Abbi engaged appropriately.

The Care Coordinator sought urgent medical advice regarding recommencement of Clozapine through re-titration and alternative treatment options if this was declined, resulting in an urgent Consultant review. Following assessment, the Care Coordinator and Clozaril Nurse met with Abbi to discuss restarting Clozapine; however Abbi decided not to do so, reporting that the newly prescribed Quetiapine and Promethazine were working well. This view was also reflected by staff within her supported accommodation and acknowledged by the Trust.

In response the Trust has taken the following actions:

- A Trust wide audit of benzodiazepine prescribing in the community has been commissioned to provide assurance that all prescribing adheres to NICE Guidelines and BNF guidance regarding indication, dosage, duration, and review, with findings informing quality improvement actions where required.

- Consultant Psychiatrists are required to adhere to Trust policy and NICE guidance on benzodiazepine prescribing, with particular emphasis on short term use, clear documentation of clinical rationale, and explicit review dates. Adherence continues to be monitored via direct supervision reviews.

- Non-attendance by a patient prescribed time-limited medication (such as benzodiazepines) will trigger an urgent review of treatment plan, raised jointly by the Care Coordinator and the prescribing medic, to ensure the ongoing appropriateness of the prescription is actively assessed.

- The Care Coordinator who was involved in Abbi's care now ensures that all email documentation is saved on the patient's records. In addition, Trust wide training has been delivered on the importance of ensuring full records are stored / saved in a timely manner into patient records.

These standards are being re-enforced across community services through the Trust's Community First transformation programme, which aims to deliver a structural reduction in Consultant caseloads to ensure that clinical oversight and escalation are consistently achieved in practice.

**Concern 4)** Abbi remained on a treatment regime during her last admission and discharge at the mental health Trust that was known and recorded as had not been previously successful. Abbi had positively responded to Clozapine in the past such that Abbi was discharged to supported living from the Tier 4 specialist unit. Abbi's deterioration with continued non-compliance with Clozapine was recorded by the local community Consultant Psychiatrist as predicted and inevitable. No plans were put in place to mitigate this.

**Response:**

The Trust accepts that whilst the risk of deterioration was recognised, the subsequent change in Abbi's treatment engagement was not escalated in a way that allowed the original risk mitigation plan to be reviewed and amended.

Whilst concern 3 indicates that the emergency plan was not followed, whereas concern 4 suggests that a treatment regime was in place, it is the Trust's respectful submission that the Consultant acted appropriately in October 2021, documenting the clinical risk clearly, introducing an interim bridging regime, and arranging a medical review for December 2021.

Critically, at the October 2021 review Abbi agreed to restart Clozapine, and the Consultant's plan was therefore clinically sound and made on the basis of that agreement.

Following the October review Abbi subsequently told her Care Coordinator that she would not restart Clozapine. Clozapine is a treatment that requires consistent patient engagement. Variable or intermittent compliance is not clinically viable and recommencement requires re-titration under controlled conditions.

The Trust however acknowledges that this change in Abbi's position was not escalated back to the Consultant. The Trust acknowledges that the Care Coordinator was regularly seeing Abbi and there was no observed clinical deterioration apparent at those contacts.

In response the Trust has taken the following actions:

- Upon staff becoming aware that a patient is not taking their medication as prescribed, immediate escalation is made to the responsible Consultant Psychiatrist, the case is discussed at the multidisciplinary team (MDT) meeting, risk is formally assessed and RAG-rated within the zoning meeting, and an agreed action plan is documented; a copy of the MDT minutes is uploaded to the patient's electronic record (PARIS) and circulated to all relevant professionals.

- Supported living providers working with complex patients are now included in safety and escalation planning at the point of discharge and at Care Programme Approach reviews.

These standards are being reinforced across community services through the Trust's Community First transformation programme, which will deliver a structural reduction in Consultant caseloads to ensure that the oversight and risk mitigation planning required for complex patients is consistently achieved in practice.

**Concern 5)** Abbi deteriorated significantly at the end of January 2022 and February 2022 requiring police to take Abbi to a place of safety due to her presentation and level of self-harm and suicidality that required a Mental Health Act assessment. Professional concerns were raised about inaccurate clinical information contained in the documentation from the

Approved Mental Health Act Professional (AMHP) that were about another patient. Abbi made a video about the contents of this letter that reinforced her view that professionals did not care about her. Abbi received an apology about the inaccuracies in this AMHP assessment shortly before her death.

**Response:**

Please note that the AMHP service is not provided by EPUT, this is provided by Essex County Council (ECC) who would be best placed to respond to this concern.

**Concern 6)** There were issues in communication and sharing of information. Evidence was that some EPUT staff did not appreciate Abbi's history and did not read the medical records or query inconsistencies. Not all clinical contacts were appropriately recorded.

**Response:**

The Trust accepts that there were occasions where relevant historical information was not fully considered and where clinical contacts were not recorded consistently.

A task and finish group was established as part of the Trust PSII Review Action Plan in respect of the vital importance of records review. In response to this concern, staff have been reminded again to review relevant patient history and gather information from family (where there is consent to do so). As per the evidence presented in court such reminders form part of structured supervision meetings as well as service governance meetings.

Staff continue to ensure the family are given a voice in relation to key information and relevant history, this is facilitated by inviting families to MDT meetings (if the patient agrees) and direct access to medical and nursing teams.

Trust services also use the MaST tool to monitor and audit caseloads. MaST employs an algorithm which takes into account a number of different factors that might influence a patient's needs – like housing, medications, disabilities and other health conditions – and highlights where a patient may need additional support. The dashboard highlights patients who may be at increased risk of crisis. It also flags when patients have not been contacted recently, or need a follow-up appointment. While MaST is not designed to replace clinical expertise and judgement in managing their caseloads, it brings a range of relevant information into one place, enabling informed, evidence-based decisions.

**Concern 7)** Staff supporting Abbi were not trained in Autism or how to communicate with Abbi as a neurodivergent person with a learning disability. Expert evidence was that there was insufficient exploration of how this impacted specifically on Abbi and how best to communicate with her and how information should have been presented to her about her diagnosis, care and treatment. The evidence of some later training was not considered sufficient.

**Response:**

The Trust accepts that greater consideration could have been given to how Abbi's autism and learning disability influenced her communication needs, understanding of diagnosis and engagement with services.

All staff are now required to take part in the national mandatory Oliver McGowan training which was legislated on 1st July 2022, and rolled out at EPUT in 2023.

A number of steps have been taken to address Neurodiversity support within the Inpatient setting. There is a section on page 41/42 in the EPUT Therapeutic Acute Inpatient Operating Model for Adults and Older Adults' (2024) with the heading 'Adults with a learning disability and autistic adults' which includes 'reasonable adjustments' and NHSE Guidance references, which includes key actions which need to take place for adults with a learning disability and autistic adults.

A range of different initiates are available on different wards, within the Linden Centre there are now Sensory Rooms within three of the wards (including Galleywood). The sensory rooms have dimmed lights, sensory equipment such as sensory chairs, rocking chairs, black out blinds, projectors, a water bed, and weighted blankets. These rooms have been developed with the help of Occupational Therapists, Psychology and the patients themselves and are available to use 24/7.

In additional sensory boxes are available for the patients' individual rooms within the Linden and Crystal Centres. These include risk assessed items such as fidget toys, bands, ice packs. Should the individual have their own individual sensory items these can be included to enable a patient centred approach.

Patients with an identified Neurodiversity need / diagnosis will have a specified care plan suited to their needs working alongside the MDT. Staff are also clear to seek the support of Psychology when a need is identified as well as the Trust- Autism Specialist, Dr Dakin.

In respect of our Community care, guidance in relation to the managing of persons with a learning disability or autism are set out in the Transforming Care Programme which is a UK health and social care initiative established in 2012 following the Winterbourne case. This guidance aims to reduce reliance on inpatient care and enhance community-based support. It's driven by the "Building the Right Support" strategy and involves various initiatives across health and social care sectors

The key goal of the program aims to improve the quality of care and quality of life for people with learning disabilities and/or autism, and to reduce inappropriate hospital admissions and lengths of stay by enhancing community based support.

All clinicians are trained in their core training to make reasonable adjustments. This is covered in mandatory training.

Mid and South Essex Integrated Care Board (MSE ICB) commissioned Essex County Council (ECC) to provide these services which is in the form of the 'Transforming Care Team'. ECC manages the Dynamic Support Register (DSR) which is a register of people with learning disability and/or autism who are at increased risk of hospital admissions. Community Teams and other parties are able to make referrals into the DSR panel where they are discussed and if appropriate added to the register.

Where it is noted that risks are increasing in the community, a Community Care Treatment Review (CCTR) is held to review what appropriate support should be provided to mitigate a hospital admission. These reviews are also held prior to discharge from an inpatient setting, and is known as a Care Treatment Review (CTR). 'Case Handlers' from the Transforming Care Team work across inpatient settings with the inpatient services and Community Mental Health Teams looking at appropriate discharge planning. This was not in place at the time of Abbi's passing and is still developing.

The Gables Specialist Mental Health Team (SMHT) have recruited a new post, a Community and Inpatient Liaison Practitioner Community Psychiatric Nurse (CPN). This role is intended to work directly with inpatient services.

This member of staff will meet with the patients on the ward, attend ward reviews and work closely with the inpatient team to ensure a safe discharge, improve communication and provide a more seamless service. It is anticipated that having a CPN involved from admission will allow earlier identification and communication with other providers involved in the person's care.

From a psychology perspective, a number of staff within the Trust have undertaken the National Autism Training Programme which has a specific focus on inpatient settings. The in-patient Psychology team have used this framework to develop a one day training around working with Autistic individuals for inpatient staff. This has been in operation for approximately 2 years at the Trust.

In-patient Psychologists support around PBS (Positive Behaviour Support Plans) and CTRs (Care and Treatment Reviews). In terms of community teams, we have psychologists based in community teams who work to support colleagues around reasonable adjustments for working with Autistic individuals.

**Concern 8)** There were no professionals' meetings to consider how best to respond to Abbi when in crisis and how crisis could be mitigated to avoid hospital admission. Abbi was a complex young woman who suffered an obvious and predicted deterioration.

**Response:**

The Trust has considered this concern is detail. The Trust acknowledges that the MDT meetings should manage the risks involved with the individuals and their families.
The Trust acknowledges that, given the complexity of Abbi's presentation and the recognised risk of deterioration, there should have been greater multidisciplinary oversight and more structured crisis planning to reduce the risk of hospital admission.

In response, the Trust has strengthened arrangements to ensure that patients presenting with deterioration, increased risk, or medication non-compliance are promptly escalated to the responsible Consultant Psychiatrist, discussed within MDT and zoning meetings, and managed through documented risk assessments and action plans. Supported living providers are now routinely included in safety planning and CPA reviews to improve coordinated responses during periods of crisis. Where relevant other professional are involved and professional meeting are coordinated accordingly.

As stated above, the Trust has also implemented the MaST tool to identify patients at increased risk of crisis in order to facilitate earlier review. The Trust rolled out this tool from April 2024, which is now in place across all community teams. In addition, patients with autism and/or learning disabilities can now be referred through the Dynamic Support Register and Community Care and Treatment Review processes to bring agencies together to consider enhanced community support and alternatives to hospital admission.

These improvements are being further embedded through the Community First transformation programme, which is strengthening MDT oversight, consultant involvement, and risk management arrangements for patients with complex needs.

The Trust recognises the importance of coordinated multi-agency working in supporting individuals with autism and/or learning disabilities who may be at risk of crisis or hospital

admission. Patients identified as being at increased risk can be referred to the Dynamic Support Register (DSR), which is managed through the Transforming Care programme.

Whilst the DSR does not provide direct clinical intervention, it brings relevant agencies and services together to ensure that concerns are identified, information is shared, and appropriate support arrangements are considered. Where concerns arise regarding a patient on, or potentially requiring inclusion on, the DSR, this can trigger review through the relevant Transforming Care processes, including consideration by the Dynamic Support Register and, where appropriate, a Community Care and Treatment Review (CCTR).

These processes enable health, social care and other partner agencies to work collaboratively to identify needs, review existing support arrangements, and consider additional interventions that may help reduce the risk of deterioration or hospital admission. This is supplemented by existing community mental health support, multidisciplinary review, crisis services, and joint working with learning disability and autism services where appropriate.

The DSR tracks vulnerable individuals at risk of admission, while the CCTR is a formal review meeting to improve care plans and speed up community discharges.

**Concern 9)** Abbi's diazepam was continued and increased during her crisis and deterioration. Abbi was prescribed a treatment medication regime that had been unsuccessful in the past and had not mitigated attempts to end her life by ligature whilst she was detained in her last admission under the Mental Health Act.

**Response:**

The Trust accepts that continued prescribing of Diazepam should have been supported by clearer review arrangements and consultant oversight. Please see responses to concerns 3 and 4

In line with the evidence presented to the Court, Diazepam or any Benzodiazepine medication can be continued or increased in a crisis. As with most antipsychotic medications, these do not always take effect immediately. During a crisis it would be against standard clinical practice to discontinue a long-term medication unnecessarily. Each person's medication needs are considered individually and in light of their presentation.

There is now an Electronic Patient Medication System in place where clinicians are able to see the patient's previous medical history in respect of previous hospital attendances and past medication reviews. There is now greater pharmacy input in place for Inpatient Services, with pharmacists now sitting in on MDT's and supporting medication history reviews.

The Court is asked to also note the assurance set out above at concern 3

**Concern 10)** There were no up-to-date care plans and risk assessments in place for Abbi during her detention and when she was discharged to the community on 14 February 2022 to mitigate a known significant risk. Abbi had tied multiple tight ligatures during her 11-day admission under detention of the Mental Health Act and had her usual clothing removed on 4 February due to her risks, the precise date her clothing was returned, and the rationale was not recorded.

**Response:**

The Trust accepts that components of the care planning and risk assessment documentation were not updated to the standard expected and that the rationale for certain restrictive interventions was not always sufficiently recorded.

In the interests of safety and based on risk assessment, it is noted that Abbi was issued with anti-ligature clothing during her admission (with her clothes being returned after discharge); during this time her attempts at ligatures were reduced.

The provision of anti-ligature clothing is discussed and agreed by MDT. These decisions are regularly reviewed and documented. Such clothing is not used as standard.

To ensure that risk assessments are up to standard, a record keeping audit is undertaken at every shift at the Linden Centre to monitor details, accuracy and that information is up to date particularly with recent incidents. This is undertaken by the allocated qualified staff member and any identified actions are cascaded at the end of every shift. Should any staff have an identified training need this will be addressed in supervision to ensure performance management.

Management Teams and staff also have access to an electronic Trust dashboard which is specific to each ward and provides a full oversight of relevant ward information about the current patients (including records, risk assessments and care plans), this supported the identification of any record gaps that can then be promptly addressed. These are printed on a daily basis for staff.

**Concern 11)** On 9 February 2022 community mental health staff required 3 conditions to be met before they would support Abbi's discharge, none of which were met on 14 February 2022. Abbi was a very complex patient and her care co-ordinator wanted to attend Abbi's ward review on 14 February and emailed the consultant psychiatrist that she had not received a link. The ward review went ahead in absence of the care co-ordinator and concerns that the care co-ordinator had about Abbi's risks of her harming herself and ending her life on the discharge were escalated. The plan did not change.

**Response:**

Discharge Planning meetings occur throughout the patient's admission, this ensures constant focus on how to support someone through to discharge and provides enhanced opportunities for MDT in-put.

A weekly discharge planning meeting is held on each ward with all key care workers and community leads present to highlight any complex discharges. This is documented within the action plan. Meetings may still proceed without a member of the community team being present. All members of the team have access to the records / MDT notes relating to planned discharges. All MDT's and ward reviews have a member of staff from the Home First Home Team in attendance.

Abbi was reviewed by the Care Coordinator on the day following discharge. The contemporaneous clinical records indicate that the Care Coordinator assessed Abbi's presentation and concluded that ongoing follow-up by the Community Mental Health Team was appropriate and that Home Treatment Team involvement was not warranted at that stage. The risks identified at the time were recognised by both inpatient and community teams as longstanding and chronic in nature.

The discharge decision was based on the multidisciplinary assessment of risk, the patient's clinical presentation, and the judgement that ongoing management within community mental health services represented the most appropriate and proportionate care plan at that time.

It is further noted that Abbi would have also had a Care Treatment Review at point of discharge.

**Concern 12)** Abbi had anti-ligature bedding, and her room stripped of her possessions, and this remained in place at the time of her discharge. The responsible clinician was informed by a preceptorship nurse that the Home Treatment Team had refused to accept Abbi as she had a care co-ordinator. This information was known by the treating team to be incorrect, the Home Treatment team had agreed to see Abbi on 25 January 2022, and other patients had been assessed and discharged from the Ward with these arrangements previously. This was not checked or challenged, and Abbi was discharged without further discussion with professionals about an appropriate care plan

**Response:**

When a patient is presenting a significant risk towards themselves anti ligature clothing and bedding can be considered and then agreed within the MDT and within the patients ward review. This is regularly reviewed through MDTs and Ward reviews and is included in the patients care plan. Ward staff will consider an increase of observations as well to prevent further restrictions in place.

The Home First Team in-reach staff will attend all inpatient MDT meetings and also patients ward reviews, referrals are discussed where possible in advance to have a clear understanding of the intervention needed for the patient care and the plans following discharge.

**Concern 13)** Although Abbi had some dialogue about the future on 15 February 2022, she informed the community mental health team that she 'did not want to go on anymore, and had lived her life'. She was unable to give any assurances for her safety and was declining help. Advice from the Home Treatment Team was not sought and the community team wanted to step up care, but this had not been put in place and was not the process to be followed for a crisis.

**Response:**

In line with the evidence provided at the Inquest, Abbi was keen to only work with those she was familiar with and had built a good rapport with which included her Care Co-coordinator who visited Abbi at home. The community team worked hard to build this rapport with Abbi and with the community team as a whole and arrange visits to support Abbi in an attempt to build rapport.

In line with the records held on the PARIS system for the 15th February 2022 prepared by the Care coordinator, Abbi was seen at home for a face to face follow up review 48 hours post discharge. At this time whilst Abbi expressed suicidal ideation, which is noted to be ongoing and long term, no firm plan was expressed although it was acknowledged that Abbi had stated that she could not ensure her own safety. Abbi also spoke of future planning of attending a brain scan and wanting to live independently with a dog in the near future.

Although the management plan was not discussed with the Home Treatment Team, it was discussed with the team lead (MDT) and Duty team. A decision was made to provide stepped up care from the SMHT itself to maintain the provision of stability and consistency

bearing in mind the team had built a rapport with Abbi, and their knowledge of her ASD condition and her need for familiarity with the professional she worked with.

Furthermore, the Gables SMHT is on the very same ground as to where Abbi resided which allowed for prompt access to Abbi and vice versa.

The care coordinator had planned to further discuss the situation at the upcoming Team's weekly MDT on the 17th February 2022 which was attended by psychiatrist, psychologist, OT, Social worker, nursing staff and other professional. The step up care was put in place immediately on the 15th February 2022 in person and a further visit with Abbi was scheduled for the 16th February at 10:00hrs.

It is important to note that the Home Treatment Team have 24hrs to complete their gatekeeping assessment, whereas the Gables SMHT saw her in less than 24hrs. In addition, the Gables attended to Abbi via a face to face review and made a call to Abbi on the morning of 15th February 2022 to inform her of the discussion and plan to further support her via an MDT discussion.

The Gables duly updated the team at the Pavilion where Abbi resided. It is important to note that Abbi would need to agree to the referral to the Home Treatment Team (HTT) before this could be arranged for her.

This process followed by the Gables as a community team is in line with the current pathway when managing a crisis in the community i.e. the Community are required to attempt to put in additional measures before a referral to the HTT is made.

**Concern 14)** There was a lack of understanding within the EPUT mental health teams of Care, Education and Treatment Reviews and that has continued. This could have prompted a professionals meeting for Abbi.

**Response:**

Please see response given for concern 7 above.

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.

Yours sincerely

[redacted]

[redacted]
**Interim Deputy CEO and Executive Chief People Officer**