

REGULATION 28: REPORT TO PREVENT FUTURE DEATHS (1)

*NOTE: This form is to be used **after** an inquest.*

	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS THIS REPORT IS BEING SENT TO: 1. Chief Executive Essex Partnership NHS Foundation Trust 2. Chief Executive Essex County Council
1	CORONER I am Sonia Hayes, Area Coroner, for the coroner area of Essex
2	CORONER'S LEGAL POWERS I make this report under paragraph 7, Schedule 5, of the Coroners and Justice Act 2009 and regulations 28 and 29 of the Coroners (Investigations) Regulations 2013.
3	INVESTIGATION and INQUEST On 23 May 2023 an investigation was commenced into the death of Jillian Anne Steedman, aged 71 years. The investigation concluded at the inquest on 18 June 2025. The conclusion of the inquest was Suicide: Mental health services failed to conduct a mental health assessment between 8 and 12 May 2023 when Mrs Steedman was suffering a deterioration in her mental health and was known to be in crisis. This was in the background of a known risk that a taxi could be diverted, and Mrs Steedman had expressed that she wanted to throw herself in front of a train and would find the train station. Care home staff had been instructed not to escort Mrs Steedman in the taxi and not to interfere with mental health plans. Mrs Steedman's death was contributed to by neglect. The medical cause of death was 1a Multiple Severe Injuries 1b Collision with Locomotive (Train) 2. Mental Disorder.
4	CIRCUMSTANCES OF THE DEATH Jillian Anne Steedman died on 12 May 2023 at Pitsea Station in Basildon of Multiple Severe Injuries due to Collision with a Locomotive (Train) in a background of deteriorating Mental Health Disorder. Mrs Steedman was discharged from a long detention mental health hospital to a care home on 11 April 2023 with ongoing Electroconvulsive Therapy for resistant depression and the required post-treatment monitoring was not done. Mental health services were informed by Mrs Steedman that she wanted to jump in front of a train on 15 April 2023 and her presentation fluctuated. On 27 April the care home raised concerns at a professionals meeting to the mental health team and social care

	about Mrs Steedman the risk of diverting a taxi due to her mental health problems and suicidal thoughts. This concern was not escalated, and no risk assessment was completed. Mrs Steedman's mental health deteriorated in May and was escalated to mental health services on or around 8 May who failed to respond. Mrs Steedman was known to be in mental health crisis on 10 May and mental health services failed to attend and complete an assessment. Mental health services failed to complete a mental health assessment on 11 May 2023. Mrs Steedman redirected a taxi on the morning of 12 May 2023 to the train station and intentionally went into the path of the oncoming train with the express purpose of ending her life.
5	<u>CORONER'S CONCERNS</u> During the course of the inquest the evidence revealed matters giving rise to concern. In my opinion there is a risk that future deaths will occur unless action is taken. In the circumstances it is my statutory duty to report to you. The MATTERS OF CONCERN are as follows. – (1) There was a lack of information sharing between professionals involved in the care and treatment of Jillian Steedman who was a complex mental health patient with a long history of treatment resistant mental disorder. (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. Essex Partnership NHS Foundation Trust (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. (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. (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. (6) The mental health Trust staff and the local authority social worker were visiting Mrs 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. (7) Visiting Professionals did not complete the required reviews necessary when Mrs Steedman was distressed and experiencing crises. (8) The appropriateness of the placement was not reviewed following a crisis on 15 April 2023 just a few days after admission. (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. (10) The Trust investigation following Mrs Steedman's death did not: - 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. - Note significant deficiencies in the mental health Trust risk
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	assessment completed and sent to the Care Home later on 5 May 2023 that made no reference to: i. 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. ii. concerns raised by the care home that Mrs Steedman was expressing ongoing suicidal thoughts and may divert the taxi to the train station iii. 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 iv. 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. c. 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. d. 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. e. 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. f. 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
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	retrospective entry and the medical record was accessed after Mrs Steedman's death. Essex County Council (11) The information for the aftercare planning and assessment presented for placement and risk for Mrs Steedman placed before the panel was significantly out of date. There was no review and the s117 care plan had not been updated since 13 September 2022. (12) The social worker did not raise any alerts as to deficiencies or absence of plans following crises for Mrs Steedman. (13) There was no contact list provided as part of the integrated plan, and Mrs Steedman requested that her social worker be contacted when she was in crisis on 15 April, and she stated she wanted to die and would throw herself in front of a train. This led to the call being diverted to mental health crisis and not directly to the FIRST team in accordance with the plan. The appropriateness of the placement in the care home was not reviewed at that time or when the care home management expressed concerns about Mrs Steedman's risks of diverting a taxi. (14) There was an absence of a Council investigation and confusion as to which organisation should take the lead following Mrs Steedman's death and then dispute before the inquest on the Investigation Report provided by the mental health Trust at the inquest. This caused concerns that lessons have not been learned.
6	ACTION SHOULD BE TAKEN In my opinion action should be taken to prevent future deaths and I believe you and your organisation have the power to take such action.
7	YOUR RESPONSE You are under a duty to respond to this report within 56 days of the date of this report, namely by 3 December 2025. I, the coroner, may extend the period. Your response must contain details of action taken or proposed to be taken, setting out the timetable for action. Otherwise, you must explain why no action is proposed.
8	COPIES and PUBLICATION

	I have sent a copy of my report to the Chief Coroner and to the following Interested Persons: • Family (Son) • Care Quality Commission • British Transport Police • Care Home • Care Home Manager I have also sent a copy to the following who may find it of interest: Integrated Commissioning Board I am also under a duty to send the Chief Coroner a copy of your response. The Chief Coroner may publish either or both in a complete or redacted or summary form. He may send a copy of this report to any person who he believes may find it useful or of interest. You may make representations to me, the coroner, at the time of your response, about the release or the publication of your response by the Chief Coroner.
9	10 October 2025 HM Area Coroner for Essex Sonia Hayes