	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO:** **Chief Executive Officer of Essex Partnership NHS Trust,** [redacted] *Essex Partnership University NHS Foundation Trust,* *The Lodge, Lodge Approach, Runwell, Wickford, SS11 7XX*
1	**CORONER** I am Rebecca Mundy, assistant 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 4 August 2023 I commenced an investigation into the death of Nadia Wyatt, 53. The investigation concluded at the end of the inquest on 8 January 2024. The conclusion of the inquest was suicide.
4	**CIRCUMSTANCES OF THE DEATH** Nadia was a 53-year-old woman who had been struggling with issues affecting her mental health, namely severe anxiety, separation anxiety and depression initially in 2014 and then again from May 2023. Her separation anxiety had become so severe that it also began to impact her husband and his ability to leave her alone for any significant length of time and carry out his own work. She saw her GP on 16 and 30 June, and on 30 June she was referred to the Crisis Response Team. On both 5 and 8 July, she left a note for her family and took a taxi to a train station and multi-storey car park respectively. On each of those occasions, Nadia was found by police and taken to hospital. From 10 July she received specialist in-patient care at the Peter Bruff Unit, before being discharged home on 17 July under the care of the Crisis Home Treatment Team, who attended upon her either in person or virtually until 25 July. From 23 July she began to reach out to other professional colleagues (she had been a counsellor herself) via text message and email and made desperate pleas for help, to such an extent that one of these professionals called the police. On 26 July she recorded a video message for her daughter and left a handwritten note for her husband and daughter. She took sleeping tablets and appeared to have drunk some wine as well. When her husband returned home that evening, he found her hanging [redacted]. A post-mortem examination confirmed the medical cause of death to be; 1a Hanging. The toxicology report was consistent with medication that Nadia had been taking, both prescribed and over the counter remedies. Despite a clear desire to want to get better, intervention from professionals and the

	support of a dedicated husband, Nadia's mental health declined to such an extent that she appeared to be unable to cope with her life as it had become. I concluded that she undertook the act of hanging herself [redacted], that act caused her death and that Nadia intended that that would be the outcome.
5	**CORONER'S CONCERNS** During the course of the inquest the evidence revealed matters giving rise to concern. In my opinion there is a risk that future deaths could 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) Failure to update Nadia's records with the outcomes of referrals that were made and whether such referrals were accepted or declined, either for Nadia or her carer. (2) Failure to include within her records considerations and professional opinions reached on the prospect, or not, of readmission for in-patient treatment together with the final decision and rationale. (3) Lack of bespoke care plans tailored to Nadia's needs. Notwithstanding the fact Nadia had begun to disengage and declined to be involved in her care planning, more personalised plans could have been drafted taking into account her personal characteristics, needs and past medical history. (4) Evidence of "cutting and pasting" into Nadia's care plan from another patient's care plan. (5) Failing to undertake risk assessments at all relevant and appropriate stages and/or failure to record that such an assessment had in fact taken place and what the outcome was. (6) Failing to provide a "RAG" rating to risk assessments and/or to indicate where required that a risk exists. (7) Failure to include risk management and contingency planning within Nadia's care plans as well as key elements of her condition at that time, including her recent inpatient admission. (8) The potential for over-reliance on Nadia's husband, albeit he was only too willing to support her and care for her, and the need to balance maintaining Nadia's care and treatment in the community with the need to support her carer as well.
6	**ACTION SHOULD BE TAKEN** In my opinion action should be taken to prevent future deaths and I believe you and/or 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 11 March 2024. 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 Nadia's husband, [redacted] I have also sent it to The Care Quality Commission, who may find it useful or of interest. 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	**15 January 2024**

HM Assistant Coroner

Rebecca Munday