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 Constable of Essex Police**
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 6 July 2022 an investigation was commenced into the death of Aminata COULIBALY, aged 51 years. The investigation concluded at the inquest on 21 November 2025. The conclusion of the jury inquest was: In conclusion, Ms Aminata Coulibaly died from acute alcohol toxicity, the mechanism of which was respiratory depression. The manner in which the alcohol got in her system cannot be determined. Her death was not a deliberate act initiated by herself to end her own life. In addition to the possible causes to her death noted in section 3, the below admitted failings by interested persons are probable causes of Aminata's death; • The victims code was not adhered to by Essex Police, • Aminata was informed incorrectly that the case was closed by Essex Police. The following is a failing by Essex Partnership University NHS Trust, which is a probable cause of Ms Aminata's death; • Inadequate case management and lack of recorded background information around next of kin and known friends, lack of continuity in carers and consideration of individual risk.

4	**CIRCUMSTANCES OF THE DEATH** Ms Aminata Coulibaly passed away between the evening of the Friday 24th June 2022 to the morning of Saturday 25th June 2022. She died on her bed in her bedroom at her home address, 12 Hutchinson Close, Tiptree, Colchester, Essex from acute alcohol toxicity, the mechanism for which was respiratory depression. The manner in which the alcohol got in her system cannot be determined. Anxiety and depression are considered contributing factors to her death. The interviews of suspects for an alleged Hate Crime appear to have been below standard an admitted failing by Essex Police is a non causative factor to Aminata's death. Possible causations to Aminata's death include the following admitted failings by interested persons; • Safeguarding referral was not made by Essex Partnership University NHS Foundation Trust. • No Case Action Plan was completed by Essex Police Additionally, the following was a failure which could possibly have contributed to Aminata's death; • Failure to appropriately safeguard Aminata by Essex Police.
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) Essex Police were aware that Aminata Coulibaly was under the care of the crisis mental health team and that the exacerbation of her mental health crisis was linked to a matter that was being investigated as a Hate Crime. Essex Police did not update the mental health Trust that Aminata Coulibaly sent 2 emails on 22 June 2022 in response to her being informed (incorrectly) that the Hate Crime investigation by Essex Police had been closed: i. to the officer in the case, setting out elements of how she is being treated, elements of the hate crime and that she is not happy

with the decisions made by Essex Police and she feels like taking her life.

ii. to the Quality Service Team that was forwarded to the Hate Crime police sergeant on 23 June 2022, stating that Aminata Coulibaly wants to contest the decision made by the officer to close the case and that she is facing suicidal thoughts, anxiety and depression.

These were not uploaded to Athena or the shared with the mental health Trust.

2. Aminata made a very distressed phone call to the officer in the case on 24 June 2022 and this was not placed on Athena or shared with the mental health Trust.

3. On 26 June 2022 the mental health Trust called Essex Police reporting concerns for Ms Coulibaly's welfare. The Essex Police contact handler did not record important information reported by the mental health Trust that:

   a. Aminata had suffered assault and racial abuse by her neighbours
   b. The mental health Trust had texted Aminata Coulibaly to say that if they did not hear from her by 5pm then they would contact the police for a welfare check.
   c. Aminata Coulibaly has been having strong thoughts to end her life.

4. On 26 June 2022 a different Essex Police contact handler contacted the mental health Trust to update them on the outcome of their concern for welfare that the police would not attend as it did not meet the criteria. The contact did not ask for clarification when the mental health Trust nurse raised concern when informed that the decision was made that police were not going to attend when he asked, *"even though it is life and limb?"*. The contact handler did not clarify if there had been any update in the circumstances, these words had not been used by the Trust nurse in the first call.

The evidence from the Force Control Room Inspector was that the contact handlers should have recorded relevant information and sought further clarification that this should have been relayed back to her. This would not have made a difference for Aminata Coulibaly as she was probably

	deceased but is relevant to prevent a future death and ensure that the Inspector has all relevant information when applying THRIVE to assess risk and response.
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 21 January 2026. 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 • Essex Partnership University NHS Foundation Trust • East of England Ambulance NHS Trust • Hate Crime Officer in the Case Essex Police 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	[redacted] **26 November 2025** **HM Area Coroner for Essex Sonia Hayes**