



Chief Coroner

REPORT TO PREVENT FUTURE DEATHS REGULATION 28 OF THE CORONERS (INVESTIGATIONS) REGULATIONS 2013

If during an investigation, a coroner becomes concerned about circumstances that create a risk of future deaths, Paragraph 7 of Schedule 5, Coroners and Justice Act 2009, provides coroners with the duty to make reports to a person, organisation, local authority or government department or agency where the coroner believes that action should be taken to prevent future deaths. That report is called a Prevention of Future Deaths Report (PFD report).

The Chief Coroner provides this template to support coroners in the effective and consistent exercise of their statutory duties under the Coroners and Justice Act 2009 and Regulations 28 and 29 of the Coroners (Investigations) Regulations 2013.

The purpose of the template is to provide a clear and structured framework for setting out the matters of concern identified during an investigation which, in the coroner's opinion, give rise to a risk of future deaths. It is designed to promote clarity, ensure that reports are formulated in a way that enables recipients to understand and address the concerns raised, and to support good practice across jurisdictions.

The template does not fetter judicial independence: coroners remain responsible for determining the facts, identifying the matters of concern, and drafting reports that accurately reflect the circumstances of each individual case. The template may be adapted as necessary to ensure that the report properly and precisely records the coroner's views.

In accordance with the Chief Coroner's [PFD Publication Policy \(2026\)](#) any applications for redactions to content or general publication of the report must be sent to the coroner. The coroner will provide the representations to the Chief Coroner for a decision.

**REPORT TO PREVENT FUTURE DEATHS
REGULATION 28 OF THE CORONERS (INVESTIGATIONS) REGULATIONS
2013**

Please do not include any living persons' names in this document, in accordance with the Chief Coroner's [PFD Publication Policy \(2026\)](#).

1. CORONER

I am Bina Patel, Area Coroner, for the coroner area of Bedfordshire & Luton.

2. DATE OF REPORT

30 April 2026

3. 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. THIS REPORT IS BEING SENT TO

1. Unilever PLC
- 2.
- 3.

You are under a duty to respond to this report within 56 days of the date of this report, namely by 25 June 2026. I, the coroner, may extend the period if an appropriate application is made.

4. YOUR RESPONSE

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.

I have a duty to send a copy of your response to the Chief Coroner.

In accordance with the Chief Coroner's Publication Policy, you should send me any representations regarding publication of your response. These representations should be made at the same time as the response is provided. I will pass any representations received to the Chief Coroner for a decision.

Please note any links to webpages included in the response will not be checked for sensitive information prior to publication, as the information is already online.

	<p>The names of those who do not respond to PFD reports are regularly published on the Chief Coroner's webpages Non-responses to Prevention of Future Death (PFD) reports - Courts and Tribunals Judiciary.</p>
5.	<p>SUMMARY OF CORONER'S CONCERN</p> <p>From the contents of the letters left by Moira and the evidence heard at the inquest, Moira raised concerns over a protracted period of time from July 2022 to October 2024 and a referral was not made to occupational health which would have triggered the use of the stress risk assessment and provided support both for Moira and those within the management team.</p>
6.	<p>ACTION SHOULD BE TAKEN</p> <p>In my opinion unless action is taken to address the above concerns then there is a significant risk of future deaths and I believe you have the power to take such action.</p>
7.	<p>INVESTIGATION AND INQUEST</p> <p>On 22 April 2025, I commenced an investigation into the death of Moira Diane Parker, aged 54 years. This inquest was concluded on the 18 March 2026.</p> <p>The medical cause of death was 1 a Fatal Haemorrhage and Haemothorax 1 b Stab Wounds to Neck and Wrist</p> <p>How, when and where On 11 April 2025 Moira was found at Priory Marina River Bank, Barkers Lane, Bedford with stab wounds that were self-inflicted in the neck and wrist.</p> <p>Conclusion Suicide - The Deceased intentionally took her own life following a deterioration in her mental health after a decline in her cognitive function.</p>
8.	<p>CIRCUMSTANCES OF DEATH</p> <p>The Deceased, a Microbiologist, had worked for Unilever for thirty-six years in research and Development ("R&D"), which was a job she loved. She had struggled with mental and physical health issues for several years, which included a decline in her memory and cognitive function. These were being investigated by her GP through scans and blood tests. She was placed on Hormone Replacement Therapy to assist with her symptoms thought to be linked with menopause and although she reported some initial improvement when she commenced therapy, her underlying memory and brain function issues continued to exist since October 2022. Subsequently, she found herself under increasing pressure at work. She raised issues about her workload and an increase in her working hours that included weekends, during meetings</p>

	<p>with her line manager in December 2022, March 2023 and in October 2024 when she said she reported that was struggling to keep up with workload. A marked change in her demeanour was noticed by management in January 2025 where she appeared withdrawn and anxious. On the 5 February 2025 she contacted her GP through an eConsult reporting an escalation of her memory issues, panic attacks and feelings of being unable to cope, burnt out, the following day she certified herself sick from work. Although she was open about her health issues and work-related pressures, an occupational health referral was not made by management until 14 February 2025, after she went on sick leave. Following this, she had an appointment with her GP on the 20 February 2025 where she discussed her symptoms and there was an exploration of possible physical and psychological causes. A subsequent CT scan revealed no physical abnormalities, but her bloods identified low folate and subclinical hypothyroidism and medication was prescribed. A referral was also made to the Memory Assessment Service for further investigation for her ongoing symptoms. She was under the care of the Memory Assessment Service from the 12 March 2025 to the 27 March 2025, on the afternoon of the 11 April 2025 she was found at Priory Marina River Bank, Barkers Lane, Bedford with stab wounds that were self-inflicted in the neck and wrist. Emergency Services attended but her death was confirmed by paramedics at 13:40 hours. She had last been seen at 07:30 hours that morning when she had left her home informing her husband, she was attending her GP surgery to collect a fit note for work. Notes were left.</p>
9.	<p>CORONER'S CONCERNS</p> <p>During the course of the inquest I heard evidence 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.</p> <p>The MATTERS OF CONCERN are as follows:</p> <p>From the contents of the letters left by Moira and the evidence heard at the inquest, Moira raised concerns over a protracted period of time from July 2022 to October 2024 and a referral was not made to occupational health which would have triggered the use of the stress risk assessment and provided support both for Moira and those within the management team at Unilever, I am not satisfied staff have sufficient knowledge and training about the circumstances in which an occupational health referral can be made and the support that is available.</p>
10.	<p>COPIES AND PUBLICATION OF THIS REPORT</p> <p>I have a duty to send a copy of my report to every Interested Person who in my opinion should receive it.</p> <p>I also may send a copy of the report to any other person who I believe may find it useful or of interest.</p> <p>I can confirm I have sent the report to:</p>

[please do not use individual's names, but instead roles/titles]

1. The family of Moira Parker
2. Unilever PLC
3. Zello UK Limited (Occupational Health)
4. GP Partner & GPs at Goldington Avenue Surgery

I also have a duty to send a copy of the report to the Chief Coroner.

You may make representations to me, the coroner, about the publication of the contents of this report in line with Chief Coroner's [PFD Publication Policy \(2026\)](#). Any representations will be sent to the Chief Coroner alongside the report. Please refer to box 4 above for additional information relating to the publication of reports and responses.

SIGNATURE

A solid black rectangular box redacting the signature of the coroner.