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 Sonia Hayes, Area Coroner, for the coroner area of Essex.
2.	**DATE OF REPORT** **27 May 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. Chief Executive of Essex Partnership University NHS Trust** You are under a duty to respond to this report within 56 days of the date of this report, namely by 22 July 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. 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.
5.	**SUMMARY OF CORONER'S CONCERN** **Essex Partnership University NHS Foundation Trust (EPUT)** 1. accurate record-keeping to share information and inform clinical care 2. appropriate medication and compliance with national guidance in prescribing 3. individualised appropriate up-to-date care plans and risk assessments 4. appropriate discharge planning with care co-ordinators being involved and facilitated to attend with a structured process 5. appropriate staff training for communication and patient centred treatment for those with mental health diagnosis and autism 6. supervision of preceptorship nurses and not challenging information that is shared and known to be incorrect in discharge planning from mental health detention

	7. conducting appropriate observations with care and management of risk of self-harm and suicide permitting patients to have access to ligature material
6.	**ACTION SHOULD BE TAKEN** In my opinion unless action is taken to address the above concerns then there is a significant risk of future deaths, and I believe each of you have the power to take such action.
7.	**INVESTIGATION AND INQUEST** On 21 February 2022, I commenced an investigation into the death of Abbigail Louise SMITH, aged 26 years. The investigation concluded at the end of the inquest on 24 October 2025 . The conclusion of the inquest was 1(a) Compression of the Neck by Ligature Suicide: there were a number of failures that contributed to Abbi's death: 1. A failure by all clinical professionals and care for, treat and communicate with Abbi as a neurodivergent person with Autism that exacerbated Abbi's presentation and risk of self-harm and suicide. There was no staff training for Autism. 2.There was a complete absence and understanding of Care and Treatment Reviews for those responsible for caring for Abbi and whilst non-statutory , Abbi was entitled to these as an Autistic person who also had learning difficulties and would have assisted to get the right professionals together to look to avoid hospital admission. 3. Abbi's suffered an obvious and predicted deterioration in her mental health when she was not compliant with her Clozapine medication and the failure to follow-up on the community psychiatrist's directions in October 2021 caused her to deteriorate further with no assessment of her capacity that had been advised. Abbi's short-term prescription of diazepam was continued without a required medical review and failed to comply with NICE Guidelines. Abbi was prescribed a treatment medication regime that had been unsuccessful in the past and had not mitigated her ligaturing to attempt to end her life whilst she was detained. 4. Although Abbi had some dialogue about the future on 15 February, she informed the community mental health team that she did not want to go on anymore, had lived her life, could not 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 for a crisis. 5.There was a gross failure to provide and procure basic medical attention for Abbigail when she was discharged from detention under the Mental Health Act on 14 February 2022 with no plan to mitigate the real and immediate risk Abbi posed to herself with threats, plans and actions to end her life. Abbi had anti-ligature bedding, and her room stripped of her possessions, and this remained in place prior to her discharge. There were no up-to-date care plans and risk assessments in place for Abbi to manage this risk or for when she was discharged to the community on 14 February 2022 to mitigate this known significant risk. Abbi had tied multiple tight ligatures during her 11-day admission and had her usual clothing removed on 4 February due to her risks, the precise date her clothing was returned was not recorded. 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. This discharge was not safe. The care co-ordinator informed the treating team and responsible clinician that she wanted to attend the ward review on 14 February and had not received a link. The ward review went ahead without the care co-ordinator, and no attempt was made to contact her. 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 with a real and immediate risk to her life. Abbi's death was avoidable and contributed to by neglect.
8.	**CIRCUMSTANCES OF THE DEATH** Abbigail Louise Smith (Abbi) was found on 15 February 2022 at Braintree Recreation Ground at about 23:25 hours. Resuscitation was unsuccessful and Abbi pronounced deceased at 00:08 hours on 16 February 2022 due to Compression of the Neck caused by Abbi [redacted]

	[redacted] Abbi had unsuccessfully tried to suspend herself [redacted]. Abbi had a known history Autism and Learning Disability and had spent many years detained under the Mental Health Act and there is disputed evidence as to her mental health diagnosis. Abbi had a sustained positive response to Clozapine such that she was discharged to supported living as the attempts to end her life had ceased. Abbi became non-compliant with her medication in September/October 2021, and this was reported to community mental health services. The directions of the consultant psychiatrist, who noted a serious deterioration in her mental health was inevitable, were not followed up and Abbi remained on a medication regime that was known not to work. Abbigail required assessment under the Mental Health Act on 25 and 27 January 2022 when she made attempts to end her life and was sectioned under the Mental Health Act and admitted to hospital. Abbi made numerous attempts to end her life by ligature whilst detained. Abbi was discharged on 14 February 2022 to her supported living accommodation with no plan to mitigate the known fatal risks she posed to herself. The conditions required by the community team to facilitate a safe discharge had not been met and no alternative plan had been put in place. Abbi had indicated on 15 February 2022 that she could not give an assurance that she could keep herself safe and wanted to end her life.
9.	**CORONER'S CONCERNS** 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. The **MATTERS OF CONCERN** are as follows: 1. Abbi spent most of her adult life in detention and was 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. 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. 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 in Abbi Diazepam was prescribed. 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.

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.

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.

7. Staff at 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.

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.

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.

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.

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's 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.

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.

13. Although Abbi had some dialogue about the future on 15 February, she informed the community mental health team that she did not want to go on anymore, had lived her life, could not 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. 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.
10.	**COPIES AND PUBLICATION OF THIS REPORT** I have a duty to send a copy of my report to every Interested Person who in my opinion should receive it. I also may send a copy of the report to any other person who I believe may find it useful or of interest. I can confirm I have sent the report to: 1. Care Quality Commission 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