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 Cygnet Health Care** 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** 1. There were inaccuracies and omissions in her medical records about Abbi's diagnosis, care and treatment during her care and treatment. 2. Significant change in mental health diagnosis was not highlighted in the records or shared appropriately with other healthcare professionals. 3. Medical records contained significant cutting and pasting rather than individualised care. 4. No adjustments or adaptions were made to communications with or therapy offered to Abbi as a person diagnosed with Autism and learning difficulties, that discouraged active participation in therapy and patient centred care planning.

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 , an investigation was commenced into the death of Abbigail Louise SMITH, AGE 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 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] 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 detained and over 18 months in a specialist Tier 4 mental hospital having been transferred there by her local mental health trust. The Tier 4 specialist team agreed that Abbi did not have a personality disorder. This was a significant change for Abbi and was not accurately set out in the discharge summary. 2. Objectively and subjectively Abbi had appeared to respond positively to Clozapine medication with which she was compliant such that Abbi was discharged back to the care of her local community mental health Trust . The medical records and documentation contained significant cutting and pasting and the change of mental health diagnosis was not contained within the Psychology records. 3. Expert evidence was there was no individualised care plan recorded for Abbi There were inaccuracies and omissions in her medical records about Abbi's diagnosis, care and treatment during her care and treatment that were then shared and relied upon by other healthcare professionals in other Trusts. 4. It was known that Abbi was diagnosed with Autism in her childhood and had learning difficulties. Abbi informed the specialist team that she found group work difficult. No adjustments or adaptions were made to communications with or therapy offered to Abbi. 5. Medication regimes and changes were not accurately recorded in the medical records, and this included for medication that required statutory monitoring and was difficult to decipher even at the inquest.
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: *[please do not use individual's names, but instead roles/titles]* 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