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** **1 June 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 Partnerships University NHS Foundation Trust** You are under a duty to respond to this report within 56 days of the date of this report, namely by 26 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. Ms Corrigan was prevented from accessing healthcare related to an ongoing hormonal disorder for which she had been receiving treatment prior to her detention. The treating consultant had contacted both the mental health team and the Responsible Clinician and received no response to his correspondence. 2. There were significant omissions in clinical detail and recording in medical records. 3. There was a lack of qualified and appropriately trained staff on the ward and there was a lack of compliance with the Trust's policies in conducting the risk assessments for Section 17 Leave. 4. Ms Corrigan's Section 17 leave was rescinded by the Responsible Clinician due to the risk of self-harm and deterioration in mental state. Ms Corrigan was permitted to access the community on multiple occasions without the statutory permission required under

	the Mental Health Act as well as her being absent without leave not being appropriately reported or investigated. 5. Datix forms were not completed when it became known that Ms Corrigan had accessed leave on multiple occasions which did not comply with the requirements of Section 17 Mental Health Act and leave had been rescinded by the Responsible Clinician due to Ms Corrigan's risks to herself. 6. Ms Corrigan's Family was encouraged to privately fund psychoanalytic psychotherapy in the community without the knowledge or understanding that Ms Corrigan did not want to undergo this therapy. Expert evidence is that it was not appropriate in all the circumstances. 7. There were known issues around the appropriate staff skills mix for the ward and an overreliance on preceptorship nurses. 8. Changes implemented for section 17 leave and observations from paper to electronic records led to confusion and loss of visibility of key data useful for staff implementing the systems. Key senior staff were not consulted and there was no audit of efficacy of the change in systems.
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 8 January 2024, I commenced an investigation into the death of Katharine Emma CORRIGAN, aged 27 years. The investigation concluded at the end of the inquest on 12 March 2026. The conclusion of the inquest was 1(a) Consistent with Hanging Section 4 (Part 1) We as the jury have concluded based on the evidence seen and heard in court, that Katharine's death is suicide and narrative. There is a history of maternal suicide in Katharine's family. Katharine had suicidal thoughts and tried to take her own life on previous occasions. We are satisfied on the balance of probability that Katharine took actions [redacted] with the intention to end her own life. Section 4 (Part 2) It is clear from the evidence that systemic failings at the mental health facility responsible for Katharine's care contributed to Katharine being able to leave unescorted on the 22nd July 2023. Staff awareness of policy and procedures was evidenced to be found lacking which led to inadequate care. Previous incidents of unauthorised leave were not adequately recorded and were not seen as an opportunity to review procedures and implement adequate oversight to ensure Katharine's safety.

	There was insufficient exploration of a pre-existing hormonal condition which was possibly a contributing factor to her emotional dysregulation. Staffing skills on the ward on the 22nd July 2023 was insufficient and lacking in oversight. The lack of senior staff involved in Katharine's risk assessment on that day led to her being allowed to access section 17 leave unescorted.
8.	**CIRCUMSTANCES OF THE DEATH** Katharine Emma Corrigan was a patient detained under the mental health act at the Linden Centre. Katharine died by suicide consistent with hanging [redacted] on 1st January 2024. It is probable the actual date of death was 22nd July 2023. This was the day Katharine failed to return from unescorted leave. Leave was granted following systematic failures over a period of time.
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. Ms Corrigan was undergoing recognised therapy consistent with the national guidelines for a pre-existing hormonal imbalance prior to her detention under the Mental Health Act and was prevented from continuing with it. Ms Corrigan's Consultant Gynaecologist telephoned the ward and wrote twice to the Responsible Clinician setting out the history and his willingness to continue to treat Ms Corrigan with permission from her treating mental health team and on the second occasion with an alternative plan for treatment under a local NHS gynaecology team. There was no response, and Ms Corrigan was prevented from accessing this therapy. Expert evidence was that this therapy was not contraindicated. None of this was recorded appropriately in the medical records and no rationale given for Ms Corrigan not having the available treatment. 2. Policies and protocols on section 17 Leave granted under the Mental Health Act (Section 17 Leave) were not properly understood by all staff and the required risk assessments were not conducted by appropriately qualified and trained staff. 3. Section 17 Leave forms and the process of recording of the required components for timings and conditions of such leave had been changed by the Trust in May 2023 from a paper system to electronic recording. The new system: a. omitted previously detailed information on the timings and conditions of the leave that included required scrutiny by a qualified mental health nurse. b. Staff then recorded some information on the Bed State document and evidence was this was not the purpose of this document and led to lack of visibility of any patient who had not returned at the specified time. This was not questioned or queried by senior staff. c. Senior management staff gave evidence that they were unaware of the lack of visibility of the conditions for Section 17 leave under the new electronic system of recording and had not been consulted when the changes were being made. This was still the system in place.

4. There was a lack of Datix reports for Ms Corrigan accessing Section 17 leave when the leave had been rescinded by the Responsible Clinician. Datix is the incident reporting system utilised within the Trust. There had been no auditing of the new system and senior managers had not been aware that Ms Corrigan had repeatedly accessed unauthorised section 17 leave on multiple occasions prior to her death when they gave evidence at the inquest.

5. Ms Corrigan was absent without leave on multiple occasions and this had been facilitated by staff. There was a lack of scrutiny as to how and why Ms Corrigan was able to access leave that had not been authorised under section 17 Mental Health Act and/or had been rescinded by the Responsible Clinician due to risks of self-harm. On one occasion the Family went and searched for Ms Corrigan and returned her to the ward with reported risks that she was found near to train tracks and where her mother was buried.

6. Ms Corrigan's risk assessment and care plans had not been appropriately updated in her medical records such that:

    a. They had not been developed in collaboration with her and did not contain:
        i. Early waring signs and triggers
        ii. Which mitigations were appropriate
        iii. Rationale as to why section 17 leaves were granted and/or rescinded
    b. With accurate risk information of her presentation and deterioration on the ward and with concerns raised by Family which were put in writing to the responsible clinician
    c. They contained inaccurate information on fire safety that had never been a part of her presentation . It was not understood where this had emanated from.
    d. That Ms Corrigan had tried to get rid of all her clothes and this was behaviour Ms Corrigan had previously displayed before attempting to end her life.
    e. That her mental health deteriorated in the days prior to her death and staff were concerned about the risks to herself due to her low mood. Nursing staff instigated the risk protocol such that Ms Corrigan should not have been able to access section 17 leave until reviewed by the multidisciplinary team and there was confusion about the Level of observations that had been put in place for Ms Corrigan on 21 July. Medical records and section 17 leave forms were not amended to ensure that staff could understand that due to her low mood with consequent risks, leave must not take place until a medical review.

7. There were known and ongoing issues with staffing and shift planning. There was an overreliance on preceptorship nurses who the Trust knew according to national and local policy and guidance, could not undertake all the roles required on the mental health ward unsupervised.

8. Preceptorship nurses were left in charge on the mental health ward on the morning of 22 July 2023 and a qualified nurse attended several hours after the commencement of the shift. This was known about and management staff did not check that the arrangements to mitigate this had been facilitated. There was no clear understanding of how and by whom the nurse in charge role was being undertaken. This contributed to Ms Corrigan accessing the community when leave had been removed temporarily by the ward manager the previous evening in accordance with protocol. The medical records were not clearly updated to reflect this, and the Section 17 Leave form had not been updated.

	9. Expert evidence was that Dialectic Behavioural Therapy can be useful for a patient like Ms Corrigan to attempt to find strategies for learned maladaptive behaviours with complex trauma. Ms Corrigan's family were encouraged to privately fund intensive psychoanalytical psychotherapy as a mitigation for Ms Corrigan's significant risk of killing herself. Expert evidence was that this was not a therapy modality which was understood to be appropriate for Ms Corrigan: a. specifically, to mitigate a significant and immediate risk of her ending her life b. for a detained patient with her presenting mental state and risks and, c. when Ms Corrigan had indicated that she did not wish to participate in it. d. When Ms Corrigan had not completed DBT. e. who was reporting nightmares and flashbacks of complex trauma. f. When it was understood by the professionals that this therapy would last for years and would involve delving into the unconscious. 10. The Family had raised repeated concerns that Ms Corrigan was not receiving appropriate treatment on the ward and about the risks to herself, verbally and in writing. The Family correspondence contained communications evidencing their concerns emanating from Ms Corrigan herself in text messages to the responsible clinician and other staff. Ms Corrigan was encouraged to undergo intensive psychoanalytical psychotherapy even though she explained she did not feel ready and her family did not know or understand about how rare this form of therapy is and relied on her treating clinical team. They were encouraged to fund this and convey her to the therapy in the community without an understanding that Ms Corrigan did not wish for it. 11. A digital system 'Oxehealth' was used to observe Ms Corrigan using tweezers as a risk item. This is not the purpose of this system.
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 2. Expert Witness – Consultant Psychiatrist 3. Psychoanalytical Psychotherapist 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.
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