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 Stephen SIMBLET, HM Assistant Coroner, for the coroner area of Essex.
2.	**DATE OF REPORT** 15 July 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.
4.	**THIS REPORT IS BEING SENT TO** 1. [redacted] 2. EPUT INQUESTS You are under a duty to respond to this report within 56 days of the date of this report, namely by September 09, 2026. I, the coroner, may extend the period if an appropriate application is made.
5.	**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.
6.	**SUMMARY OF CORONER'S CONCERN**

7.	**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.
8.	**INVESTIGATION AND INQUEST** On 22 May 2025 I commenced an investigation into the death of Tia Ann BIRKITT aged 20. The inquest was completed on 15th July 2026, with a narrative conclusion. The deceased took a substantial overdose of her prescribed propranolol medication while at home. An ambulance was called and the deceased received treatment and was conveyed to the Princess Alexandra Hospital for further treatment. By the time of her arrival at hospital the deceased was unconscious. Efforts to resuscitate her were unsuccessful and she died in the emergency department at the hospital at 02:30 on 18th May 2025.
9.	**CIRCUMSTANCES OF DEATH** On 22 May 2025 I commenced an investigation into the death of Tia Ann BIRKITT aged 20. The inquest was completed on 15th July 2026, with a narrative conclusion. The deceased took a substantial overdose of her prescribed propranolol medication while at home. An ambulance was called and the deceased received treatment and was conveyed to the Princess Alexandra Hospital for further treatment. By the time of her arrival at hospital the deceased was unconscious. Efforts to resuscitate her were unsuccessful and she died in the emergency department at the hospital at 02:30 on 18th May 2025.
10.	**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) There is a concern that arrangements for the consideration of referrals made by GP practices in Essex may not lead to acceptance by mental health services or adequate further treatment, or be fully understood in the referral process. (2) there is a concern that patients with presentations such as autism and communication difficulties such as selective mutism may either not have those difficulties adequately considered in determining what further treatment or referral is to be provided, or may not have adequately explained to them or

	their families how such treatments or further referrals may actually be delivered in a manner that takes account of those difficulties.
11.	**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]* • [redacted] 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.
12.	**SIGNATURE** [redacted] **Stephen SIMBLET** **HM Assistant Coroner for Essex**