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 Nadia Persaud, Area Coroner, for the coroner area of East London.
2.	**DATE OF REPORT** **13 August 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], Chief Executive Officer, North-East London NHS Foundation Trust 2. 3. You are under duty to respond to this report within 56 days of the date of this report, namely by **9 October 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** **(1) There was a lack of formulation and management of risk to self, following a clear and concerning deterioration in Mrs. Laird's mental state.** **(2) A safeguarding child referral was made without any checks into the foundation for such a report. No support was provided to Mrs. Laird – a patient suffering a mental health crisis – to help navigate the consequences and effect of a safeguarding referral.**
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 2 February 2026, I commenced an investigation into the death of Miriam Laird (nee Camilleri), aged 45 years. The investigation concluded on the date of the final inquest hearing – 6 August 2026. **The medical cause of death was:** 1a Asphyxia by ligature **How, when and where:** Miriam Laird suffered from depressive disorder with anxiety and experienced a significant decline in her mental health from early January 2026. She left her home to receive support from her parents, on 10 January 2026. On the 11 January 2026 she was taken to hospital due to concerns about her mental health. From this time, she came under the care of the secondary mental health services in North East London. She received regular assessment from the home treatment team. From the 21 January 2026 she was presenting with an increased risk of suicide. Despite the increased risk of suicide there is no documented formulation of her risk to herself. There is no documented risk management plan to address the increased level of risk. Her medications were adjusted on the 29 January 2026 but otherwise her care plan remained unchanged. On the 31 January 2026 Mrs. Laird was found deceased in her bed at the home address of her parents. [redacted] Paramedics pronounced her life extinct on scene ([redacted]). Police attended, investigated and found no suspicious circumstances. **Conclusion:** Mrs Laird died as a result of suicide.

9.	**CIRCUMSTANCES OF DEATH** (1) On the 21 January 2026 the treating team were made aware by a family member, that Mrs. Laird had been researching ways to end her life. The disclosure was not fully explored with Mrs Laird in a private, safe and therapeutic space. There was no evidence of any fresh formulation of her risk to self, or consideration of how to manage any increased risk to self. On the 27 January 2026, Mrs Laird disclosed that whilst she did not wish to end her life, she wanted to die to escape unbearable emotional pain. She expressed wanting a pill to end her life. Again, there was no fresh formulation of her risk to self, or review of the safety plan to reduce the risk of harm to self. (2) When Mrs. Laird presented to A&E in early January 2026, she was seen by the psychiatric liaison team who assessed her as being very unwell. As she had a young child, a child safeguarding referral was made. Mrs. Laird was not caring for her child at this time. She had put in place appropriate care arrangements during her period of ill health. The safeguarding referral resulted in a social worker contacting Mrs. Laird. This caused Mrs. Laird a great deal of distress. No support or assistance was provided to her to support her in navigating the consequences and effect of a safeguarding referral. There was no joint working between the mental health team and social services team. It is likely that contact from the social services team exacerbated Mrs Laird's mental health decline. It also appears that fears of the involvement of the social services team prevented Mrs Laird from accepting necessary in-patient care for her mental health.

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 was a lack of attention to risk formulation and to risk management at times where risk to self clearly appeared to be increasing. (2) The child safeguarding referral appears to have been made automatically without any proper enquiry into the circumstances of the child. (3) There was a lack of multi-agency support provided to a mental health patient in crisis, to assist her in navigating the consequences of a child safeguarding referral.
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:

	1. Family of Mrs Laird 2. Care Quality Commission 3. Local Director of Public Health 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] **13 August 2026**