REGULATION 28: REPORT TO PREVENT FUTURE DEATHS

	THIS REPORT IS BEING SENT TO: **1. Maggie Oldham, Chief Executive, St Mary's Hospital, Isle of Wight NHS Trust, Newport, Isle of Wight, PO30 5TG.** **2. Lesley Stevens, Director of Mental Health and Learning Disabilities, St Mary's Hospital, Isle of Wight NHS Trust, Newport, Isle of Wight, PO0 5TG.**
1	**CORONER** I am Caroline Sarah Sumeray, Senior Coroner for the Coroner Area of the Isle of Wight.
2	**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	**INVESTIGATION and INQUEST** On 16th March 2018 I commenced an investigation into the death of Natalie Zara HUNTER, aged 33. The investigation concluded at the end of the inquest on 4th December 2018. The conclusion of the inquest was "Natalie Zara HUNTER killed herself". The medical cause of death was found to be: 1a Hanging 1b 1c II
4	**CIRCUMSTANCES OF THE DEATH** 1) Natalie Zara HUNTER was born on 24th July 1984 in Newport, Isle of Wight. At the time of her death she was 33 years old. She resided in East Cowes, Isle of Wight and was unemployed. 2) Miss HUNTER had a long and sad history which all appeared to stem from the loss of her 14-month old daughter in 2007 who had died from Septicaemia which had rapidly developed from Croup. After her daughter's death, Miss

Hunter developed a history of mental health issues and alcohol related problems. These issues caused her to make 18 serious but unsuccessful attempts on her life, via various different means, between June 2011 and February 2018.

3) On 16th March 2018, Miss Hunter's family were becoming increasingly concerned as they hadn't managed to make contact with her. She was subsequently discovered, clearly deceased, in her apartment, [redacted] having suspended herself by a ligature tied around her neck made from a dressing gown belt, which was tied to a door handle. At post-mortem, she was found to have 151mg/dL of alcohol in her blood as well as Zopiclone, Trazodone and Quetiapine metabolites. The medications were all at a therapeutic level and had been prescribed to her.

4) Miss Hunter was pronounced dead at 16.08 hours on 16th March 2018.

5 **CORONER'S CONCERNS**

During the course of the inquest the evidence revealed matters giving rise to concern. In my opinion there is a risk that future deaths will occur unless action is taken. In the circumstances it is my statutory duty to report to you.

The **MATTERS OF CONCERN** are as follows: –

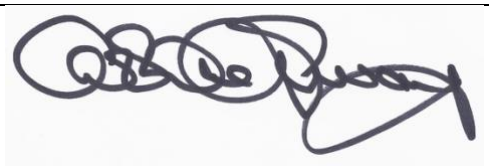
1. Natalie HUNTER's GP, [redacted] gave live evidence about Miss HUNTER's 18 previous serious attempts to take her life. During the course of his evidence he referred to the lack of Discharge Summaries from the Isle of Wight NHS Trust. He said it is not uncommon for a Discharge Summary not to be sent to a GP's practice by the IOW NHS Trust, or if it is sent, for it to be sent very late after the patient has been discharged from the Trust.

2. [redacted] raised concerns about this as the Discharge Summary should contain details of why the patient was admitted; what care they received during their time at the IOW NHS Trust; what medication they were prescribed, and whether such medication was intended to be continued; and whether there were going to require ongoing care/treatment as a result of this admission/treatment.

3. If no Discharge Summary is received, it has a big impact on the care that GPs are able to offer to their patients and the continuity of care which is needed, particularly in relation to mental health input.

4. On several occasions, [redacted] had been unaware of the nature of the admissions (which were almost all linked to her serious suicidal attempts) – and

	significantly the ongoing risk of further attempts on Miss HUNTER's life as he had either not received a Discharge Summary or had received it too late for it to have any meaningful input into Miss HUNTER's care. 5. During the course of the live evidence I heard from [redacted], Service Manager for Community Mental Health Services at the Isle of Wight NHS Trust, in connection with the lack of sufficient numbers of out-of-hours mental health or Crisis staff which are available across the Isle of Wight. His evidence (which has since been supplemented by up-to-date figures), was that the team currently comprises of 11.1 full-time equivalent Band 6 mental health staff members, but it really requires 15.74 full-time equivalent appropriately qualified staff members which would necessitate 4.64 full-time equivalent additional staff to be funded and recruited in order to be able to offer a full and effective service. 6. The evidence was that there are currently insufficient funds in order for a full complement of out-of-hours mental health/Crisis staff to be deployed which is affecting the way in which the Mental Health service operates and delivers care to those who need it out-of-hours. 7. Accordingly, I have concerns that those who are vulnerable with mental health issues and who need to be seen out-of-hours are currently not in receipt of an adequately staffed out-of-hours mental health provision.
6	**ACTION SHOULD BE TAKEN** In my opinion action should be taken to prevent future deaths and I believe you and/or your organisation have the power to take such action.
7	**YOUR RESPONSE** You are under a duty to respond to this report within 56 days of the date of this report, namely by 12th February 2019. I, the Coroner, may extend the period. 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.
8	**COPIES and PUBLICATION** I have sent a copy of my report to the Chief Coroner and to the following Interested Persons: [redacted], [redacted], [redacted], [redacted] (Service Manager for Community Mental Health Services at the Isle of Wight NHS Trust). I am also under a duty to send the Chief Coroner a copy of your response. The Chief Coroner may publish either or both in a complete or redacted or summary form. He may send a copy of this report to any person who he believes may find it useful or of interest. You may make representations to me, the Coroner, at the time of your response, about the release or the publication of your response by the Chief Coroner.

9	 **H.M. Senior Coroner – Isle of Wight** **18th December 2018**