REGULATION 28: REPORT TO PREVENT FUTURE DEATHS

	THIS REPORT IS BEING SENT TO: **1. [redacted], General Manager for the National Trust on the Isle of Wight, Longstone Farmhouse, Mottistone, Isle of Wight, PO30 4EA** **2. [redacted], Director of Public Health, Suicide Prevention Group, Isle of Wight Council, Jubilee Stores, County Hall, Newport, Isle of Wight, PO30 1UD**
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 1st March 2018 I commenced an investigation into the death of Joanna Sarah Louise Orpin, aged 42. The investigation concluded at the end of the inquest on 17th December 2019. The conclusion of the inquest was a short form conclusion as follows: "Joanna Sarah Louise Orpin killed herself." The medical cause of death was found to be: 1a Multiple Traumatic Injuries. 1b 1c II
4	**CIRCUMSTANCES OF THE DEATH** 1) Joanna Sarah Louise Orpin was born on 19th January 1976. At the time of her death she was 42 years old and worked as a Senior Recruitment Consultant. 2) In late November 2017 Miss Orpin had developed a lingering cough and chest infection and visited her GP who prescribed her antibiotics.

3) She had two teleconsultations with a GP at her practice on 16th and 19th January. During the course of the latter one, it was clear that she was highly stressed, agitated and anxious, so her GP prescribed Diazepam for her severe anxiety. A further review was diarised for 22nd January.

4) At the consultation on 22nd January, it was clear to her GP that she was still very anxious and agitated and was not sleeping, so she was prescribed Mirtazepine and a referral was made to Primary Care "Improving Access to Psychological Therapies".

5) Miss Orpin's mother contacted the GP the following day (23rd January 2018) to say that her daughter was still struggling to sleep and remained anxious.

6) On 24th January 2018, Miss Orpin attended the GP's surgery and was seen in an emergency appointment. The GP assessed her as being very anxious and she expressed many negative thoughts and a feeling of worthlessness. She had no active suicidal plans but had thoughts of not wanting to be there. Her presentation was both unkempt and agitated. The GP arranged for an urgent referral to the Hospital Mental Health Team due to her agitated depression deteriorating so significantly over a short period of time. A face-to-face assessment was booked for the following day with a Mental Health Nurse. Again, her presentation was described as being severely anxious, agitated and restless. She paced around the room as she spoke. The Nurse referred her on to the Home Treatment Team and arranged an appointment with a Consultant Psychiatrist the next day. Her medication had been increased to include Zopiclone and Quetiapine, but her presentation had not altered from agitated depression.

7) The Home Treatment team indicated that they planned to visit Miss Orpin daily to help her manage her mental health crisis. These visits commenced on 27th January 2018 except when Miss Orpin requested a family day with her partner and two young sons. They were interspersed with appointments to titrate her medication. Her agitated depression remained resistant to treatment. Miss Orpin's presentation varied a little on occasion, and she had better days as well as days when she continued to feel deeply anxious and agitated.

8) By 7th February 2018, Miss Orpin had asked to reduce the Home Treatment Team's visits to every third day. In reality, she declined visits over 5 consecutive days before agreeing to be visited again by the Home Treatment Team on 12th February 2018. On that occasion she was feeling very low; she was tearful and anxious. She didn't believe that her medication was working, and she had

	become stuck in a cycle of negative thinking. She had no suicidal plan or intent. She agreed to a visit from a Consultant Psychiatrist the following day. As with all her other visits from the Home Treatment Team, no risk of harm was identified, and she underwent a Mental State Examination and assessment of capacity. 9) The following morning, 13th February 2018, Miss Orpin woke up early and went downstairs to feed her sons breakfast and hot chocolate whilst her partner slept. She then told the children that she was going to go for a run, which is something she hadn't done for a while. By the time her partner woke up she had gone and taken the car – something she wasn't supposed to do whilst on these potent medications. 10) Miss Orpin's partner immediately took their boys out to search for her. She was not at the local Tesco supermarket, and when he drove up to Culver Cliff, he did not see her vehicle there. Having dropped the boys with Miss Orpin's mother, he heard that Miss Orpin's car had now been located in the car park at Culver Cliff. (It was later discovered that she had stopped off to buy some cigarettes at a shop en route to Culver Cliff.) Miss Orpin's partner immediately returned to discover a large police presence which Miss Orpin's disappearance, as a vulnerable person due to her fragile mental state, had generated. 11) Amongst the Police personnel present was a dog handler whose dog tracked Miss Orpin's scent approximately a quarter of a mile from the car park, where she had left her unlocked car, to a kissing gate in the main fence which runs along the length of the cliff edge. It was at that point that Miss Orpin's scent could be detected no longer, and the logical inference was that she had crossed over the kissing gate and protective fence at that point. Later, her car keys and mobile phone were found and had been thrown approximately 5 metres from this point. It should be mentioned that the weather conditions on this day were atrocious with high winds which would have forced anyone back inland from the edge of the cliff, with cold rain coming in sideways. No trace of Miss Orpin could be found on that date. 12) Whilst Miss Orpin's trainers were found at the base of the cliff at a later date, Miss Orpin's body was not located until 18th February 2018 when she was found naked on mudflats at Bosham Quay, Chichester, West Sussex.
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. I heard evidence from Inspector [redacted] that there are at least 3 or 4 people per month who are found in a state of mental distress at Culver Cliff who require the assistance of the Police or other agencies to ensure their safety. 2. I was also informed that whilst there used to be signs at the top of Culver Cliff akin to those which are found at Beachy Head in East Sussex and the Itchen Bridge in Southampton which have wording such as "Suicidal? Despairing? Call Samaritans on [local number]", these signs appear to no longer be present. (Since the Inquest, I have been provided with the following proof that these signs once existed from [redacted]: https://www.alamy.com/culver-down-uk-07th-july-2018-a-samaritans-sign-on-the-edge-of-culver-cliff-on-the-isle-of-wight-uk-reads-talk-to-us-if-things-are-getting-to-you-posted-after-a-spate-of-suicides-from-the-same-spot-yachts-can-be-seen-passing-in-the-background-during-the-round-the-island-yacht-race-on-the-hottest-recorded-day-of-the-year-so-far-at-33-degrees-celcius-credit-matthew-blythealamy-live-news-image211378076.html) 3. During the course of his evidence, Inspector [redacted] told the Inquest that he had made recommendations for these signs to be displayed approximately 3 years ago, and he was aware that a Consultant Psychiatrist had made similar recommendations within the last 12 months. Concerns had been ventilated in relation to how many signs would be required and at what intervals. It was the opinion of Inspector [redacted] that just a small number of strategically placed signs (perhaps in the car park, and at various intervals along the length of the fence as well as at places where it is easier to cross the protective fence at the kissing gate) would be adequate – in his words, "If they save just one life, then it would be worthwhile." I agree with his views. 4. I also heard evidence from [redacted], a Consultant Psychiatrist at the Isle of Wight NHS Trust that he sits on a Suicide Prevention Group, and they had also tried to get these signs reinstated at the top of Culver Cliff, to no avail.
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 11th February 2020. 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], Inspector [redacted], [redacted], 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** **31st December 2019**