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. Mr Simon Bryant FFPH, 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 15th August 2019 I commenced an investigation into the death of Annette Jane Lewis, aged 55. The investigation concluded at the end of the inquest on 8th January 2020. The conclusion of the inquest was a short form conclusion as follows: "Open Conclusion." The medical cause of death was found to be: 1a Severe Multiple Traumatic Injuries. 1b 1c II
4	**CIRCUMSTANCES OF THE DEATH** 1) Annette Jane Lewis was born on 13th May 1964. At the time of her death she was 55 years old and worked as an Artist. 2) On Tuesday 30th July 2019, Mrs Lewis and her husband went to bed, but Mrs Lewis became agitated and got up and started to bang her head against the

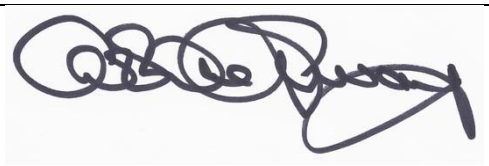
caravan wall. She became distressed, so her husband sought help from the 999 emergency number and was redirected to speak with the Crisis team. An ambulance was summonsed, but then Mrs Lewis returned to a calm state, and the ambulance was cancelled by [redacted]

3) At around 2 a.m. that night Mrs Lewis complained to her husband of a tingling feeling in the side of her face, her arm and her hand. As they were both concerned by this development, [redacted] took Mrs Lewis to the A&E department of St Mary's Hospital, Isle of Wight NHS Trust. There, she requested a blood test to check for anaemia as she was concerned that due to her raw vegan and juice diet lifestyle, that she might be deficient in some vitamins and minerals. She was triaged by a nurse and assessed by a Middle Grade Clinician in the department and it was decided that she should see her GP about this issue the following week. No tests were undertaken, and [redacted] returned home. Mrs Lewis was still restless and performed an enema upon herself and informed her husband that she felt like she was trying to pass a tumour and had lost a lot of blood, which [redacted] could see on the bathroom floor. For the second time that night he summonsed an ambulance which took them back to the A&E department of St Mary's Hospital, Isle of Wight NHS Trust.

4) Upon arrival, Mrs Lewis was again triaged, and seen by the same Middle Grade Clinician who had seen her approximately four hours earlier. She was fully examined, and a number of tests were carried out, but no abnormal findings were made – there was no evidence of any rectal bleed. In evidence, it was clear that the Clinician who had seen her twice and had two discussions with her found her to be odd, but not obviously mentally ill. He had not been informed about the initial episode of head-banging against the wall and he said he may have found that information relevant had he known about it during those two later consultations. Once again, Mrs Lewis was discharged by the A&E department to go home with her husband. According to her husband, Mrs Lewis was upbeat and happy that there was nothing seriously wrong.

5) Upon returning home, Mrs Lewis cancelled plans to see her mother and son that morning and took delivery of a grocery order. She made her husband something to eat and he fell asleep in a chair in the garden, as he was tired due to such an interrupted night. He last saw his wife around 11.30 a.m.. He woke up around an hour later and was concerned to discover that his wife was not around, and she had let the chickens out and locked the front gate. He began calling her on her mobile but she did not answer as she had already died.

	6) It transpired that Mrs Lewis had gone up to Tennyson Down and had begun to behave very strangely. She was on her own and was witnessed by members of the public at around noon that day, to be in acute distress, talking to herself and screaming "Don't take my baby" (her name for her dog who had died earlier in the year), as well as singing the song "I would do anything". She had taken her top off previously, and then she removed all her other clothes so that she was completely naked. She then did a dance beside the edge of the cliff, causing the member of the public to fear for her safety and call the Police, before Mrs Lewis threw herself over the edge of the cliff with predictably catastrophic consequences. Her body was subsequently retrieved by HM Coastguard. She had left no note or explanation for her sudden actions.
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 [redacted] that there are no fences to protect the public from falling over the edge of the cliff at Tennyson Down, and moreover that there are no signs providing those in some sort of mental distress with the number for the Samaritans. Whilst I acknowledge that putting fences around the edge of the cliff would be a massive undertaking by the landowners, it may prevent a future death if those who are in extremis are reminded that there are people out there who are trained to assist them at that time. 2. Having just concluded a similar inquest involving a woman who threw herself from the top of Culver Cliff where I raised similar concerns with both the National Trust and the Director of Public Health who heads up the Suicide Prevention Group on the Isle of Wight, it seems appropriate that if consideration is being given by these organisations to better signage being implemented at the top of Culver Cliff, at the same time, consideration can also be given to making similar improvements at Tennyson Down.
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 9th March 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] 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** **13th January 2020**