M. E. Voisin
Her Majesty's Senior Coroner
Area of Avon

16th May 2019 REF: 10686

	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO:** 1. **Avon & Wiltshire Mental Health NHS Trust** 2. **The Student Health Service** 3. **Secretary of State for Health (Matt Hancock)** 4. **Minister for Suicide Prevention (Jackie Doyle-Price)**
1	**CORONER** I am M E Voisin Senior Coroner for **Area of Avon**
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 16/05/2018 I commenced an investigation into the death of Natasha Elizabeth Victoria Abrahart. The investigation concluded at the end of the inquest 16th May 2019. The conclusion of the inquest was: Suicide contributed to by neglect The medical cause of death was 1a)Hanging
4	**CIRCUMSTANCES OF THE DEATH** Natasha Abrahart died on 30th April 2018 at First Floor Flat, [redacted], Bristol; she had locked her bedroom door, placed a ligature around her neck and died as a result. At the time of her death she was under the care of the mental health team who had not provided a timely and detailed management plan following a number of assessments by them. That management plan should have been in place by the end of March 2018 and by the time Natasha was on her Easter holiday which would have instilled hope and managed her risk.
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. – The NICE guideline Depression in Adults; Recognition and management (CG90) states in section 1.5.2.7 "A person with depression started on antidepressants who is considered to present an increased suicide risk or is younger than 30 years (because of the potential increased prevalence of suicidal thoughts in the early stages of antidepressant treatment for this group) should normally be seen after 1 week and frequently thereafter as appropriate until the risk is no longer considered clinically important" In this case Sertraline was prescribed but the NICE guideline was not followed by the mental health trust or the GP practice. The expert indicated that the review at 1 week is to ensure that the patient is taking the medication, to check for any side effects including suicide risk and to see what has happened; that review can be done by the G.P. or the mental health team but there needs to be a known appointment.

6	**ACTION SHOULD BE TAKEN** In my opinion action should be taken to prevent future deaths and I believe you 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 17th July 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 – the family of the deceased, Bristol University, [redacted] and [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	16/05/2019 Signature_____ M E Voisin Senior Coroner **Area of Avon**

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