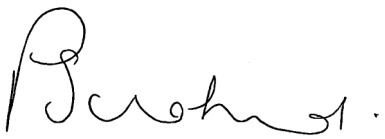
Coroner Service
West Sussex, Brighton & Hove

Regulation 28: REPORT TO PREVENT FUTURE DEATHS

	REGULATION 28 REPORT TO PREVENT DEATHS **THIS REPORT IS BEING SENT TO:** **1 Secretary of State for Health and Social Care** **39 Victoria St** **London** **SW1H 0EU** **2 NHS England** **Wellington House** **133-135 Waterloo Road** **London** **SE1 8UG** **3 National Register of Communication Professionals working with Deaf and Deafblind people.** **Portland House** **Belmont Business Park** **Durham** **DH1 1TW**
1	**CORONER** I am Penelope SCHOFIELD, Senior Coroner for the coroner area of West Sussex, Brighton and Hove
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** On 04 January 2023 I commenced an investigation into the death of Imogen Alice NUNN ("Immy") aged 25. The investigation has not yet concluded and the inquest is currently part heard and will resume on 20th May 2025.
4	**CIRCUMSTANCES OF THE DEATH** Immy, was profoundly deaf and used a cochlear implant.She suffered from complex post traumatic stress disorder and mixed personality disorder (with emotionally unstable, anxious and dependent traits).

	Although Immy could lip read she required an interpreter to assist her mental health practitioners in providing support. Interpreters were not always available (particulary at short notice) and meetings and assessments had to take place without an interpreter present. In the months leading up to her death her mental health had been deteriorating. On the evening of 31st December 2022 Immy left her assistance dog in the care of her parents and attended a party with friends. In the early hours of 1st January 2023 Immy left the party and was reported as a high risk missing person. Police Officers were able to contact Immy at 06:08 on 1st January 2023 and she stated she was safe and well at her home address. Officers have attended her home address to check in her but sadly they found Immy deceased having consumed [redacted], a substance she had bought on line approximately 6 weeks before.
5	**CORONER'S CONCERNS** During the course of the investigation my inquiries revealed matters 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: (brief summary of matters of concern) During the course of the Inquest (which has yet to be concluded) I heard evidence that there was a lack of availability of British Sign Language Interpreters able to help support Deaf patients in the community who were being treated with mental health difficulties. This was particularly apparent when mental health staff were seeking an interpreter at short notice for a patient who was in crisis. The lack of interpreters available has meant that urgent assessments are being carried out with no interpreters present. The overall lack of British Sign Language Interpreters has also meant that this Inquest has itself had to be delayed/adjourned for two months due to there being no available Interpreters to interpreter for two deaf witnesses over the two week period of the Inquest.
6	**ACTION SHOULD BE TAKEN** In my opinion action should be taken to prevent future deaths, and I believe you (and/or your organisations) 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 May 19, 2025. 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 Imogen Nunn** **South West London & St Georges Mental Health Trust** **Sussex Partnership NHS Foundation Trust** **Chief Constable of Sussex Police** **Venture People** **South East Coast Ambulance Service NHS Foundation Trust** I have also sent it to. **Ministry of Justice** **Brighton and Hove City Council** [redacted] **(Minister for Social Security and Disability)** [redacted] **(Minister for the Cabinet Office)** **British Deaf Association and National Deaf Children's Society** who may find it useful or of interest. 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	Dated: 24/03/2025  Penelope SCHOFIELD Senior Coroner for West Sussex, Brighton and Hove