Hampshire and
Isle of Wight Healthcare
NHS Foundation Trust

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[redacted]

8 December 2025

Mr Nicholas Walker
HM Area Coroner
Hampshire, Portsmouth and Southampton Coroners Service
Castle Hill
The Castle
Winchester
SO23 8UL

[redacted]

Dear Mr Walker

I write in response to the Regulation 28 Report issued following the inquest into the death of Abigail Jelley.

Firstly, I am sorry for the shortcomings in the support provided by the Trust for this young woman. The Trust's Internal Review Report and the findings from the Inquest demonstrate that the Trust's organisation and delivery of care was not as good as Abigail and her family had a right to expect.

As you state, the Perinatal Team are expert in assessing patients such as Abigail. However, they are not commissioned to complete urgent visits and must refer patients to the Community Mental Health Teams. This is an arrangement that is common in most parts of the country. The important issue is the drawing on specialist perinatal expertise when needed, through very close working between the Crisis Resolution Home Treatment Teams (CRHTs) and the specialist Perinatal Team.

The "Perinatal Red Flags" is information that is primarily targeted towards non-mental health professionals. It is not mandatory training for Mental Health Registrants, for whom it will have been an integral part of their core education in becoming a qualified mental health practitioner. What we are doing, however, is rolling out a redesigned training programme for assessing and managing all risk in mental health, and perinatal risks will be part of that programme.

Whilst there was some engagement with Abigail's family, the Trust accepts that it was clearly insufficient.

There was also a lack of professional curiosity in working with Abigail, and this has been worked on with the teams involved.

Multidisciplinary team (MDT) "huddle" meetings are now established and provide a forum for clinicians to discuss referrals and caseloads. There are also weekly MDT reviews, in which Band 7 team leaders are more directly supporting staff in their focus on urgent face-to-face assessments. Additionally, more senior clinical leadership involvement has also been provided, and the teams are being supported to implement a comprehensive Quality Improvement Plan. These measures are aimed at addressing the structural issues that you describe.

We are committed to learning, particularly from tragedies such as Abigail's death, and ensuring that everyone in our care receives the very best care and treatment possible.

If you require any further information, please do not hesitate to contact me.

Yours sincerely

**Chief Executive**