



Regulation 28: REPORT TO PREVENT FUTURE DEATHS

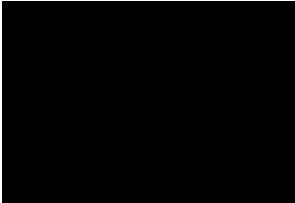
NOTE: This form is to be used **after** an inquest.

	REGULATION 28 REPORT TO PREVENT DEATHS THIS REPORT IS BEING SENT TO: 1 Hampshire and Isle of Wight Healthcare (HIOWH) (Formerly Southern Health, SHFT) 2 [REDACTED]
1	CORONER I am Nicholas WALKER, HM Area Coroner for the coroner area of Hampshire, Portsmouth and Southampton
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 13th November 2024 I commenced an investigation into the death of Abigail Eleanor Ann Jelley who was 34 when she died. The investigation concluded at the end of the inquest on 24th September 2025. The conclusion of the inquest was that Abigail died on 12th November 2024 at work premises below her home address in Waterlooville, Hampshire having intentionally harmed herself causing fatal blood loss. She intended by her act to end her life. The deceased was suffering with post-natal depression and in the weeks leading to her death she asked mental health professionals for help. It was established that there were failings in training, culture and knowledge by some of the professionals charged with Abigail's care.
4	CIRCUMSTANCES OF THE DEATH Abigail was a 34-year-old mother of two who suffered a crisis in her life from the end of October 2024 until her death a few weeks later. The crisis arose out of post-natal depression following the birth of Abigail's second child earlier in 2024. During this period she seen by different mental health professionals whose job it was to react to that crisis and attempt to assist her through it. A review into her death was critical of the care she received, and I heard evidence from those involved in the review. All teams concerned fall under the Hampshire and Isle of Wight Healthcare Trust.
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) Community Mental Health Teams do not receive mandatory training on the perinatal red flags that are used when assessing patients with postnatal mental health issues. The team concerned with Abigail did request training but, a year after Abigail's death, they had not received it. They were told that an assessment had been made by those senior to them



	that such training is not mandatory. That women suffer poor mental health before and after giving birth is sadly common and I am concerned that there is a risk of future deaths and that a large and vulnerable group of patients will not receive appropriate care. The Perinatal Team are expert in assisting patients such as Abigail. However, they are not commissioned to complete urgent visits and must refer patients to the community mental health teams who lack the specialist training and who are likely, due to the reasons outlined above, unaware of the perinatal red flags. I am concerned that women in need will not receive the appropriate mental health care and that there is a risk of future deaths. Abigail was known to the community mental health services for just a few weeks. She had been living with her parents immediately before she died and they had attended medical appointments with her. Abigail's parents were not spoken to by mental health professionals about their daughter's circumstances when they would have been able to provide valuable information about her research into and planning around ending her life. It was accepted that there was a lack of professional curiosity shown by professionals both in Abigail's case and generally and I am concerned that there is a risk of future deaths. It was accepted that there were cultural issues within the trust services. A report into Abigail's death concluded that these included 'a lack of professional curiosity, lack of escalations of deteriorating patients, non-patient centred decision making and a linear approach to risk assessment and formulation.' I am concerned that there are structural issues with the leadership of the Hampshire and Isle of Wight Healthcare Trust that is to the detriment of patients like Abigail, and I am concerned about the risk of future deaths.
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 December 08, 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 Hampshire and Isle of Wight Healthcare (HIOWH) (Formerly Southern Health, SHFT) [REDACTED] I have also sent it to [REDACTED] who may find it useful or of interest. I am also under a duty to send a copy of your response to the Chief Coroner and all interested persons who in my opinion should receive it. I may also send a copy of your response to any person who I believe may find it useful or of interest. 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: 13/10/2025  Nicholas WALKER HM Area Coroner for Hampshire, Portsmouth and Southampton