Coroner Service
West Sussex, Brighton & Hove

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 Cabinet Office** **1 Horse Guards Road, London SW1A 2HQ** **2 Secretary of State for Health and Social Care** **39 Victoria St London SW1H 0EU** **3 Minister of State, Minister for Social Security and Disability.** **Department for Work and Pensions,** **Caxton House, Tothill Street, London SW1H 9NA.** **4 Minister of State for Education** **Department of Education** **Orchard House, 20 Great Smith St, London SW1P 3BT**
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 AND INQUEST** On 04 January 2023 I commenced an investigation into the death of **Imogen Alice NUNN** ("Immy") aged 25. The investigation concluded following an Inquest on 23rd May 2025 The conclusion of the Inquest was:- On 1st January 2023 Immy died at her home address of Basement Flat, 15A, Newmarket Road, Brighton, BN2 3QG **Narrative Conclusion** On or around the 1st January 2023 Immy consumed [redacted]. Immy at the time was suffering from a deterioration of her mental health. Whilst the taking of this substance on this day may have been an impulsive risky act it is clear that when Immy obtained the [redacted] she would have been well aware of the implications of taking this substance and as such, on balance, she appears to have made a deliberate decision to take her own life. However there was a failure by the mental health services to manage her risk by a) Failing to review her care plan following a suicide attempt in October 2022. b) Failing to put in place safeguarding measures following being advised that Immy had accessed the Pro-suicide website and had disclosed that she had purchased chemicals to use in suicide. c) Failing to have a face to face appointment with Immy on the 30th December 2022 to assess her risk. This is on a background of systemic longstanding and well documented challenges in the provision of mental health for deaf patients with particular emphasis on the national shortage of BSL interpreters and the difficulty this presents for patients to be able to communicate their distress when their mental health is deteriorating or they are in crisis.

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 a BSL interpreter to assist her mental health practitioners in providing support**. Interpreters were not always available (particularly 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 on her but sadly they found Immy deceased [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) I draw to your attention that a previous Prevention of Future death report was issued on 24th March 2025 **before** the Inquest concluded. This report was issued to the Department of Health and Social Care, NHS England and the National Registers of Communication Professionals working with the Deaf and Deafblind People (NRCPD) It was issued before the Inquest had concluded as it had already become apparent that there was a real lack of British Sign Language Interpreters (BSLs) able to help support Deaf patients in the community who were being treated with mental health difficulties. This was putting this cohort of individuals at risk. The overall lack of British Sign Language Interpreters was also evidenced directly by the Court in that this Inquest has had to be delayed/adjourned for two months due to there being no available Interpreters to interpreter for two deaf/mute witnesses over the two week period of the Inquest. A joint reponse to this report from Department of Health and Social Care and NHS England has been received. Having heard further evidence in this matter, once the Inquest resumed, I felt compelled to issue a further report. My concerns are 1. **Matter for the Cabinet Office (Equalities. The Disability Unit/BSL Advisory Board. Sponsoring the Procurement Act 2023.** **AND the Minister of State (Minister for Social Security and Disability)** The Chief Executive of the NRCPD provided evidence that the Procurement Act offers NHS bodies and Integrated Care Boards (ICBs) the opportunity to collaborate with organisations like NRCPD to develop contracts that improve the delivery of BSL interpreting services. At present, contracts for interpreting services are often awarded to larger agencies, where BSL interpreting forms only a small part of broader contracts primarily focused on spoken languages, rather than being handled by agencies specialising in BSL. Evidence also highlighted the absence of

	statutory regulation for BSL interpreters. The NRCPD Chief Executive emphasised that establishing a statutory regulator would help professionalise and elevate the status of BSL interpreters, which in turn would promote the role and increase the number of specialists available to support deaf mental health patients. Since the Cabinet Office holds responsibility for disabilities, I raise these concerns regarding the national shortage of BSL interpreters and the lack of regulation in this area. 2. **Department of Health and Social Care** Evidence indicates that clinicians who are fluent in British Sign Language (BSL) provide a significantly better experience for deaf patients compared to non-BSL-speaking clinicians relying solely on interpreters. The NHS England response to the earlier Prevention of Future Deaths (PFD) report outlined the role of Integrated Care Boards (ICBs) in commissioning interpreting services for NHS Trusts. However, there is a clear shortage of BSL-proficient clinicians, and insufficient efforts are being made to recruit and retain these professionals. This gap is failing to meet the needs of deaf individuals. 3. **Matter for the Department of Education.** Evidence was heard that the lack of BSL interpreters was in part due to the lack of availability of BSL qualifications and training.
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 November 28, 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 • [redacted] • **South West London & St Georges Mental Health Trust** • **Sussex Partnership NHS Foundation Trust (SPFT)** • **Chief Constable of Sussex Police** • **Venture People** • **South East Coast Ambulance Service NHS Foundation Trust** I have also sent it to **National Registers of Communication Professionals working with Deaf and Deafblind People (NRCPD)** **Brighton and Hove City Council** 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. They may send a copy of this report to any person who they believe 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: 07/10/2025 [redacted] Penelope SCHOFIELD Senior Coroner for West Sussex, Brighton and Hove