ANNEX A

REGULATION 28: REPORT TO PREVENT FUTURE DEATHS (1)

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

	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO:** 1. Chief Executive, Cardiff and Vale University Health Board 2. West Quay Surgery, Hood Road, Barry
1	**CORONER** I am Rachel Knight, Assistant Coroner for the coroner area of South Wales Central.
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 the 4th September 2018 an inquest was opened in to the death of Mrs Ruth Ellen Edwards. The investigation concluded at the end of the inquest on 13th December 2018. The conclusion of the inquest was suicide.
4	**CIRCUMSTANCES OF THE DEATH** • Mrs Edwards died at her home address of [redacted] on the 31st August 2018 after she had hanged herself from the attic ladder. She had a long history of mental health problems and had attempted suicide a number of times. • On 23rd August 2018 she was admitted to the University Hospital of Wales following a drug overdose. She was discharged the same night and told to see her GP. She saw her GP for an assessment on 24th August and was visited regularly up until her death by the REACT team.
5	**<u>CORONER'S CONCERNS</u>** During the course of the inquest, and the investigation leading up to it, the evidence 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. – (1) Mrs Edwards' discharge from hospital following overdose on 23rd August to see GP was surprising. It was expected in these circumstances that Mrs Edwards would have been transferred to Llandough Hospital for a psychiatric liaison assessment. Instead, responsibility for any further assessment and treatment of Mrs Edwards was passed entirely to Mrs Edwards and her family. A less capable family/individual may not have pursued help and fallen through the cracks. Furthermore, had Mrs Edwards been hospitalised, her treatment may have been different. (2) The consultation at the UHW on 23rd August was poor. The history-taking was inadequate, as it did not reveal the true extent of Mrs Edwards' risk in terms of previous suicide attempts and deep-seated mental health problems. Furthermore, inaccurate information was communicated to liaison psychiatry: they were told that Mrs Edwards had taken 2 tablets, when she had taken 20. (3) The GP practice may not have performed suitably frequent medication reviews with Mrs Edwards. Many boxes of different tablets were found at the family home, many on repeat prescription, posing an overdose risk.
6	**ACTION SHOULD BE TAKEN** In my opinion action should be taken to prevent future deaths and I believe you and your organisation have the power to take such action. You may wish to consider the following points: (a) The identification of patients who require immediate psychiatric assessment and review by specialist teams; (b) The care and attention to detail taken by doctors and other healthcare professionals when noting histories and information from mental health patients; and (c) The frequency of medication reviews with mental health patients.
7	**YOUR RESPONSE** You are under a duty to respond to this report within 56 days of the date of this report, namely by 12th February 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: 1. Chief Coroner 2. The family 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	**18th December 2018** **SIGNED:**  **Miss Rachel Knight** **Assistant Coroner**