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. The Chief Executive of Powys Teaching Health Board** **2. Chief Coroner** **3. [redacted] – Daughter** **4. Minister for Health**
1	**CORONER** I am Andrew Roger Barkley, Senior 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 7th January 2016 I commenced an investigation into the death of Gillian Rose Taylor concluding at the end of an inquest on the 29th April 2016. The conclusion of the inquest was "Suicide" and the cause of death of death was 1a. Hanging.
4	**CIRCUMSTANCES OF THE DEATH** The deceased had a lengthy history of mental health issues attempting her first suicide, the evidence showed, at the age of 16. She had attempted suicide on a number of occasions in the past. She suffered a significant relapse in her mental health around August 2015 and had intensive input from the Mental Health Team – being dealt with and or contacted on an almost daily basis. On the 31st October 2015 she was detained under Section 2 of the Mental Health Act after it became clear that the input that she was having was not working and there were real concerns for her mental health and her risk of self harm/suicide. As no acute beds were available for her within the Powys area or indeed any surrounding area she was taken in the early hours of the morning to Bristol Priory Hospital where she remained until the Section was lifted on the 16th November. In the intervening period she had become physically unwell and was moved to another hospital for main stream medical care. Upon discharge home she remained under the care of the local community Mental Health Team (Crisis Resolution Home Treatment Team) until her death on the 3rd January 2016. On that day concern was raised by her daughter who was unable to contact her and when police forced entry at her home address she was discovered hanging from a ligature on a bedroom door at her address.
5	**CORONER'S CONCERNS** During the course of the inquest the evidence revealed matters giving rise to concern. In my opinion there is a risk that future deaths will 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) There is no acute facility in Powys for the treatment of acutely unwell patients, which, the evidence showed, often leads to patients being moved the length and breadth of the country to an establishment where a bed can be found. The evidence also showed that the local acute unit at the Redwood Centre in Shrewsbury had recently experienced a significant reduction in the number of acute beds available compounding and exacerbating the problem. (2) As a consequence of 1 above there is often a lack of continuity of treatment which can be to the detriment of the patient concerned. (3) The evidence showed that, on balance, it is likely that the experience of being sectioned in these circumstances had an adverse effect upon Mrs Taylor which fuelled an unwillingness, on her part, to engage with Mental Health professionals thereby increasing her risk of self harm/suicide. (4) It is believed that Powys Health Board is the only Health Board in the country that has no facility available to it for the treatment of acute admission patients in the position of Mrs Taylor.
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.
7	**YOUR RESPONSE** You are under a duty to respond to this report within 56 days of the date of this report, namely by 6th July 2016. 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 Executive of Powys Teaching Health Board, the family and the Minister for Health 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	**11th May 2016** **SIGNED:**