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, Aneurin Bevan University Health Board St Cadocs Hospital Lodge Road Caerleon Newport NP18 3XQ**
1	**CORONER** I am David Thomas Bowen, senior coroner, for the coroner area of Gwent
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 02/10/13 I commenced an investigation into the death of Mrs Georgina Lewis (d.o.b.08/11/55) The investigation concluded at the end of the inquest on 08/12/16. The conclusion of the inquest was Suicide as a result of hanging having recently been released from a psychiatric unit
4	**CIRCUMSTANCES OF THE DEATH** Mrs Lewis had been admitted to Talygarn Unit County Hospital Griffithstown on 20/09/13 as an informal patient following transfer from St Cadocs Hospital where she had been admitted following a S136 assessment, she was discharged from the unit 23/09/13 went missing from home on the 27/09/13 and was found dead in woods near home on 30/09/13
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) The decision to discharge was made without notification to or consultation with any family member. (2) Following the decision no discharge plan or follow up support was put in place. (3) There was no contemporaneous notification to her GP of the discharge or the assessment leading to discharge, in fact the GP had still not received notification by the time of discovery of Mrs Lewis body
6	**ACTION SHOULD BE TAKEN** In my opinion action should be taken to prevent future deaths and I believe you 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 25/02/17. 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] 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	**DATE 22 December 2016 David T Bowen**