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:** **CHIEF EXECUTIVE ABMU HEALTH BOARD** **1 TALBOT GATEWAY** **BAGLAN ENERGY PARK** **BAGLAN** **PORT TALBOT** **SA12 7BR**
1	**CORONER** I am **Aled Gruffydd**, Assistant Coroner, for the coroner area of SWANSEA NEATH & PORT TALBOT
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 24th December 2018 I commenced an investigation into the death of Jane Diane Livingston. The investigation concluded at the end of the inquest on the 30th September 2019. The medical cause of death is 1a pressure of the neck consistent with hanging The conclusion of the inquest as to how Ms Livingston came to her death is suicide and is as follows:- The deceased was pronounced dead on the 23rd of December 2018 at the multi story car park on Trawler Road, Swansea. The deceased died from pressure of the neck consistent with hanging. The deceased had taken her own life. The deceased had suffered with anxiety and depression for twenty years which deteriorated from November 2018 onwards. The deceased was referred for a Gateway Assessment which placed her under the care of the Assessment and Home Treatment Team on the 21/22 December 2018. The assessment was appropriate and there were no grounds to detain the deceased under the Mental Health Act 1983.
4	**CIRCUMSTANCES OF THE DEATH** The deceased was Jane Diane Livingston and she was pronounced dead on the 23rd of December 2019 at the multi storey car park on Trawler Road, Swansea. The cause of death was suicide after she was found hanging at the above location. Jane was receiving treatment for mental illness by the Community Mental Health Team

	(CMHT) and the Assessment and Home Treatment Team (AHTT). Jane was diagnosed as having depression and anxiety. Her condition was managed by her General Practitioner for twenty years until her condition deteriorated in November 2018 Jane was reviewed by a Psychiatrist on the 8th of November and was given a treatment plan recommending treatment in the Community. This plan was complied with and Jane was discharged from the crisis team on the 26th of November 2018 however remained under the care of CMHT. The evidence of the Community Psychiatric Nurse (CPN) was that on the 14th of December 2018 Jane had been reviewed by CMHT, who referred her to Cefn Coed Hospital for a gateway assessment that was conducted on the same day to determine which pathway her treatment would follow. During that review Jane stated that she wanted to be referred as a voluntary patient at hospital since if she was left at home she would contemplate suicide. During the gateway assessment this was not mentioned and the CPN conducting the gateway assessment was unable to access the CMHT review as it had not been uploaded onto the case management system. The deceased went on to have further assessments in which the CMHT review subsequently became available on the case management system.
5	**CORONER'S CONCERNS** During the course of the inquest it was apparent that the deceased's wishes for hospital treatment and the reasons behind the same were not available to the gateway assessors on the 14th of December 2018. In this case the deceased underwent further assessments therefore the effects of this situation were reduced. I am concerned however that in other cases this could result in situations where a patient's own concerns are not addressed or taken into consideration when conducting an assessment that could lead to an assessment based on incomplete information and result in another patient taking their own life. 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 gateway assessors did not have full access to the notes relating to the review and subsequent concerns that triggered the gateway assessment. This may result in the assessors not obtaining the full picture when assessing a patient and making a treatment plan based on incomplete information.
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 29 November 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 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	**4 October 2019 ……. [SIGNED BY CORONER]**