	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS THIS REPORT IS BEING SENT TO: Chief Executive, Aneurin Bevan University Health Board
1	**CORONER** I am **Caroline Saunders,** Senior Coroner for the 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 29/03/2022 an investigation was opened into the death of Lucy Amanda Jones The investigation concluded at the end of the inquest on: 20/12/2022 <u>The conclusion of the inquest was recorded as:</u> Suicide <u>The medical cause of death was:</u> 1a Asphyxia 1b Hanging 1c) Mental Illness
4	**CIRCUMSTANCES OF THE DEATH** In 2019 Lucy Amanda Jones developed a serious mental illness which caused her to become stricken with paranoia. Despite receiving treatment and support, the problems she faced became overwhelming and on 12/03/22, Lucy took her own life by hanging at [redacted] in Abergavenny.
5	**CORONER'S CONCERNS** The **MATTERS OF CONCERN** are as follows: - 1. Lucy Amanda Jones was admitted to Talygarn Ward at The County Hospital Pontypool in December 2019 under Section 2 of the Mental Health Act. On discharge from hospital, she was placed on the waiting list for Cognitive Behavioural Therapy (CBT). In evidence provided by her General Practitioner, I was informed that Lucy was still waiting for CBT at the time of her death in March 2022. 2. Following Lucy's death a concise review of the care she had received from the mental health team was undertaken. The review noted that following a consultant review in January 2022, Lucy was due to be followed up in the community within 2 weeks, but that in fact she was not seen again prior to her death. The Community Psychiatric Nurse (CPN) attempted to make contact by phone on only 2 occasions and

	did not speak to Lucy. The CPN was apparently reassured by Lucy's housemate, who had no concerns for Lucy. No efforts were made to "cold call" when Lucy could not be contacted.
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. <u>I should be grateful if the following information be provided to me:</u> 1. The steps that are being taken to ensure that patients who are so unwell to be detained under the Mental Health Act, do not have to wait for more than 2 years for psychological therapies. 2. The policy that determines what steps should be taken to ensure that mental health practitioners can be properly reassured about the health of their patients who are refusing or reluctant to engage.
7	**YOUR RESPONSE** You are under a duty to respond to this report within 56 days of the date of this report, namely 08 March 2023. I, the Coroner, may extend this 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 necessary
8	**COPIES AND PUBLICATION** I have sent a copy of my report to the Chief Coroner and the following Interested Person (s) The family of Lucy Amanda Jones Health Inspectorate Wales. 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 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: 11 January 2023** Signed: CSaunders Caroline Saunders **His Majesty's Senior Coroner for the Area of Gwent.**