Kate Robertson
Assistant Coroner for North Wales (East and Central)

	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO:** Adferiad Recovery
1	**CORONER** I am Kate Robertson, Assistant Coroner for North Wales (East and 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 27 September 2021 an investigation was commenced into the death of Emily Corfield (DOB 30/12/79) who died on 19 September 2011. The investigation concluded at the end of the inquest on 11 July 2023. The conclusion of the inquest was an alcohol related death.
4	**CIRCUMSTANCES OF THE DEATH** The circumstances of the death are as follows :- Emily Corfield was aged 41 at the time of her death. She had a past medical history of vitamin B12 deficiency, anxiety, depression and excess alcohol consumption. She had some support for her alcohol misuse. On 20 April 2021 she was admitted into hospital with coffee ground vomiting and chronic alcohol misuse. She was discharged on 26 April 2021 with outpatient OGD and was due for review by alcohol liaison as an outpatient. There was no evidence that she had had an inpatient assessment by the alcohol liaison team. On 30 May 2021 she was admitted into hospital again with coffee ground vomiting and alcohol withdrawal. There was no evidence of the alcohol liaison team involvement whilst an inpatient. Emily discharged herself against advice on 4 June 2021 having the capacity to do so. On 19 September 2021 Emily was found deceased in her bed at her home [redacted].
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 – Firstly, evidence was heard during the Inquest that Emily had self-referred on a number of occasions for support to Adferiad (formerly Cais). It could not be established whether or not Emily had received written correspondence from them relating to appointments and/or offer of support as correspondence was not retained by Adferiad. Emily was on occasion closed to the service for not having responded to correspondence. The system at the time was that communicating with service users was in writing only. It appears that more recently, policies and procedures have been established to ensure that correspondence relating to those who require support and / or contact the service is now retained though these were not provided at the Inquest. Without clear and thorough policies and procedures relating to all contact with service users or those who seek support, the organisation will not be able to adequately monitor the support processes. Secondly, it was indicated that due to resource restrictions that communication cannot be by telephone with those requiring support / service users (in writing only) and the waiting time for support sessions / counselling is long. This will have a detrimental impact and deaths may occur if the treatment and support is not afforded in a timely manner.
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 8 September 2023. I, Kate Sutherland, 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 Family of the Deceased and to the Chief Coroner. 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	Dated 14 July 2023  Signature Assistant Coroner for North Wales (East and Central)