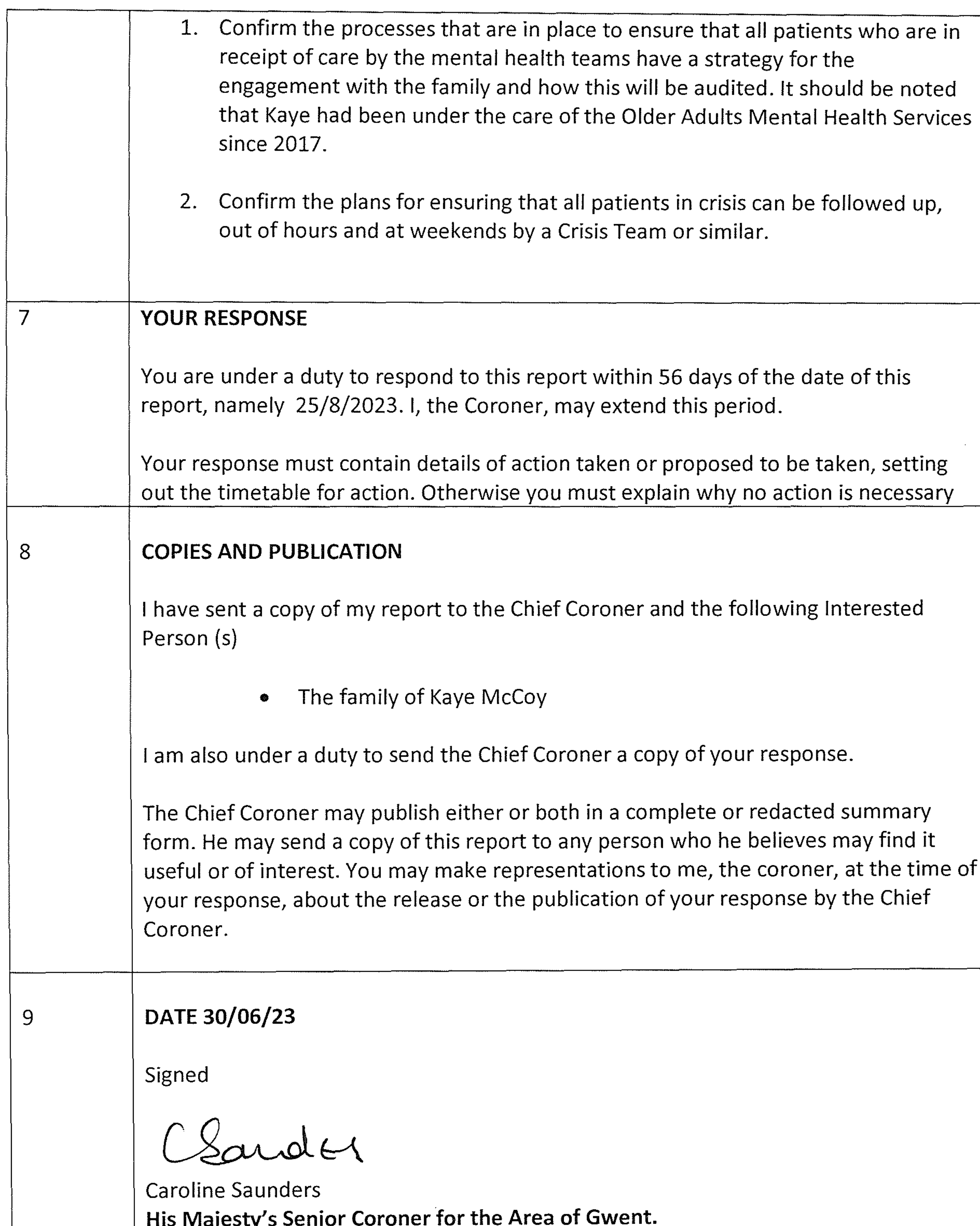
Regulations 28 and 29 of the Coroners' (Investigations) Regulations 2013

REGULATION 28: REPORT TO PREVENT FUTURE DEATHS

	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS THIS REPORT IS BEING SENT TO: The Chief Executive of 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 3/10/2022, an investigation was opened into the death of Kaye McCoy. The investigation concluded at the end of the inquest on 27/6/2023. The conclusion of the inquest was recorded as: Suicide The medical cause of death was: 1a. Suspension by ligature 1b. Unstable Affective Disorder.
4	**CIRCUMSTANCES OF THE DEATH** Kaye McCoy suffered from depression and anxiety and was diagnosed with Unstable Affective disorder. Kaye had been under the care of the Older Adults Mental Health Team since 2017 and prior to that under the care of the Adult Psychiatric Services. On 1/9/2022, Kaye had an outpatient appointment with her consultant psychiatrist who advised admission to hospital, but Kaye declined. On 5/9/2022, Kaye took an overdose of prescribed medication with an intention to end her life, she was assessed in hospital and discharged back to the care of her care co-ordinator.

	Kaye was followed up daily by her care coordinator who, on Friday 9/9/2022, again offered Kaye admission to hospital. At the inquest I determined that by this stage Kaye was in crisis and her main protective factor, which were her family, had been diluted. Kaye was expressing anger towards and was emotionally distanced from family members. The inquest found that there was no strategy developed for the involvement of Kaye's family in her care, and that engagement with the family by the mental health teams had been poor. After seeing Kaye on 9/9/2022, the next follow up was scheduled for the Monday after the weekend; 12/9/22. I was informed that follow-up and support from a Crisis or Home Treatment team was not available for Older Adults at the weekends, or indeed out of hours. Kaye was told that if her condition deteriorated she should phone the Samaritans. Kaye McCoy [redacted] taken her own life by hanging on Sunday 11/9/2022. I determined that her death was contributed to by a failure of the mental health service to adequately respond to a severe downturn in Kaye's mental health.
5	**CORONER'S CONCERNS** The **MATTERS OF CONCERN** are as follows: - At the inquest I was referred to the National Confidential Enquiry into Suicides. I was informed that the Enquiry identified key factors that should be adopted by Health Organisations to reduce the incidence of suicides, including: • That there should be a strategy for engagement with the family. • That every patient should have access to 24-hour Crisis Support Neither of these key components of care were available to Kaye. Whilst I was informed that there were steps being taken to address these I was not persuaded that these guidelines had been fully inculcated into policy and practice at Aneurin Bevan University Health Board.
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. I should be grateful if the following information be provided to me:



	1. Confirm the processes that are in place to ensure that all patients who are in receipt of care by the mental health teams have a strategy for the engagement with the family and how this will be audited. It should be noted that Kaye had been under the care of the Older Adults Mental Health Services since 2017. 2. Confirm the plans for ensuring that all patients in crisis can be followed up, out of hours and at weekends by a Crisis Team or similar.
7	**YOUR RESPONSE** You are under a duty to respond to this report within 56 days of the date of this report, namely 25/8/2023. 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 Kaye McCoy 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 30/06/23** Signed CSaunders Caroline Saunders **His Majesty's Senior Coroner for the Area of Gwent.**