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 Medical Director 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 12/2/2025 an investigation was opened touching upon the death of **Isaac Arlan Ingle-Gillis** The investigation concluded at the end of the inquest on 18/7/2025 The conclusion of the inquest was recorded as Suicide The medical cause of death was: 1a) [redacted] Toxicity
4	**CIRCUMSTANCES OF THE DEATH** Isaac Arlan Ingle-Gillis was suffering from depression. He died on 9/2/2025 at the Ty Hotel in Magor from the effects of an intentional overdose of [redacted].
5	**CORONER'S CONCERNS** The **MATTERS OF CONCERN** are as follows: - Isaac Arlan Ingle-Gillis presented to his GP on 20/12/2024 having made preparatory attempts to obtain [redacted] to end his life and had attempted to stab himself through the heart. The GP referred Isaac to the Crisis Resolution and Home Treatment Team (CRHTT), who duly assessed Isaac later that day.

	The assessment included information obtained from a telephone conversation with the GP prior to the assessment. Isaac was discharged following the assessment without follow up. Thereafter Isaac engaged with his GP but took his own life on 9/2/2025, in the circumstances described in Box 4. During the inquest I heard evidence that the CRHTT do not have access to the GP records. I could not determine on balance of probabilities that access to additional information recorded by the GP in their consultation with Isaac on 9/2/2025 would have changed the assessment made by the CRHTT on this occasion. However, I am concerned that in future this information (or lack of it) may be vital.
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 understand that Aneurin Bevan University Health Board, through the Deputy Medical Director, have a role in overseeing GP Surgeries and liaison between the inpatient and GP based teams. Kindly inform me whether there are plans to allow secondary care practitioners access to GP records.
7	**YOUR RESPONSE** You are under a duty to respond to this report within 56 days of the date of this report, namely 17 September 2025. 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 Isaac Arlan Ingle-Gillis 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 22/7/25** Signed  Caroline Saunders **His Majesty's Senior Coroner for Gwent.**