	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO:** **1. Tees, Esk and Wear Valley NHS Foundation Trust**
1	**CORONER** I am Andrew Tweddle, Senior Coroner, for the Coroner area of County Durham and Darlington.
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 21st February 2013 I commenced an investigation into the death of Linda Hudson, Age 59 years. The investigation concluded at the end of the inquest on 24th September 2013.The conclusion of the inquest was that the deceased Took Her Own Life with a medical cause of death of 1a) Hanging.
4	**CIRCUMSTANCES OF THE DEATH** The deceased had been admitted to Lanchester Road Hospital, a hospital run by Tees, Esk and Wear Valley NHS Foundation Trust following a previous suicide attempt and was discharged from the hospital on 14th February 2013. Upon discharge she was given a supply of medication which on balance was greater than that which she was able to have prescribed to her whilst in the community. In addition when she was discharged her family were not advised of this and there was thus no contact between them and the deceased. Following family concerns she was found dead in her house hanging on 16th February 2013 though it is unclear when she actually died.
5	**<u>CORONER'S CONCERNS</u>** 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. – (1) The deceased was discharged from hospital with 3 days prescription of her medication. In the community she had to collect her prescription on a daily basis to reduce the risk of self-harm or suicide. The Consultant Psychiatrist giving evidence at the inquest said that he was unaware of this. (2) Upon discharge the hospital did not contact the family to make them aware of her discharge even though family members had visited the deceased whilst in hospital. It may well have been that if the family had contacted the deceased upon her discharge and given support that her death could have been avoided. (3) The deceased was discharged from hospital on the Thursday and no follow up visit from a nurse was scheduled until the following Monday. The Consultant Psychiatrist attending the inquest giving evidence confirmed that this was too long a time taking into account all of the circumstances of the case and a nurse should have made contact with the deceased probably the next day or the Friday though he was unable to say whether this might have made any difference in all the circumstnaces.

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 by 22nd November 2013. 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	**DATED:** **A TWEDDLE LLB** **HM SENIOR CORONER** **COUNTY DURHAM AND DARLINGTON**