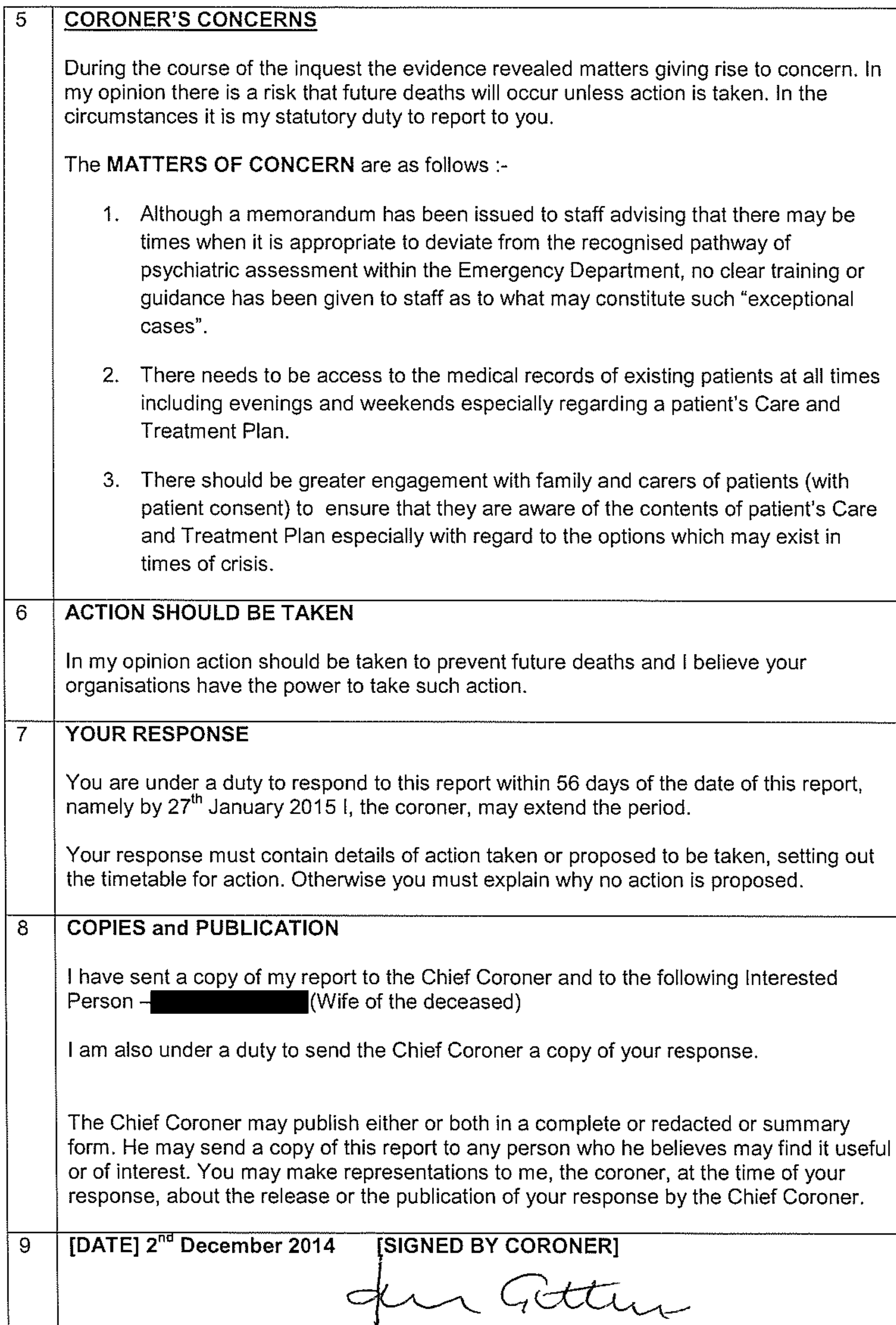
REGULATION 28: REPORT TO PREVENT FUTURE DEATHS (1)

	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS THIS REPORT IS BEING SENT TO: BCUHB, Ysbyty Gwynedd, Penrhosgarnedd, Bangor, Gwynedd LL57 2PW
1	**CORONER** I am JOHN ADRIAN GITTINS, senior coroner, for the coroner area of 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 the 13th of February 2014 I commenced an investigation into the death of Anthony Gwyn Williams, (DOB 20.05.1972, DOD 09.02.2014). The investigation concluded at the end of the inquest on the 27th of November 2014 and I recorded a narrative conclusion in the following terms :- On the 9th February 2014 Anthony Gwyn Williams was showing signs of a decline in his mental health which were typical of the condition for which he had been receiving treatment from the Mental Health Services. He expressed a wish to attend hospital for a further assessment and treatment but due to his condition he was unwilling to access such medical intervention through the recognised pathway of attendance at the Accident and Emergency Department. As a result he went to a location where he would not be easily found within Pentwmpath Woods and with the use of a ligature he took his own life whilst the balance of his mind was disturbed.
4	**CIRCUMSTANCES OF THE DEATH** The Circumstances of the death are as detailed in the above narrative conclusion.



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 :- 1. Although a memorandum has been issued to staff advising that there may be times when it is appropriate to deviate from the recognised pathway of psychiatric assessment within the Emergency Department, no clear training or guidance has been given to staff as to what may constitute such "exceptional cases". 2. There needs to be access to the medical records of existing patients at all times including evenings and weekends especially regarding a patient's Care and Treatment Plan. 3. There should be greater engagement with family and carers of patients (with patient consent) to ensure that they are aware of the contents of patient's Care and Treatment Plan especially with regard to the options which may exist in times of crisis.
6	**ACTION SHOULD BE TAKEN** In my opinion action should be taken to prevent future deaths and I believe your organisations 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 27th January 2015 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 Person – █████ (Wife of the deceased) 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	**[DATE] 2nd December 2014** **[SIGNED BY CORONER]**