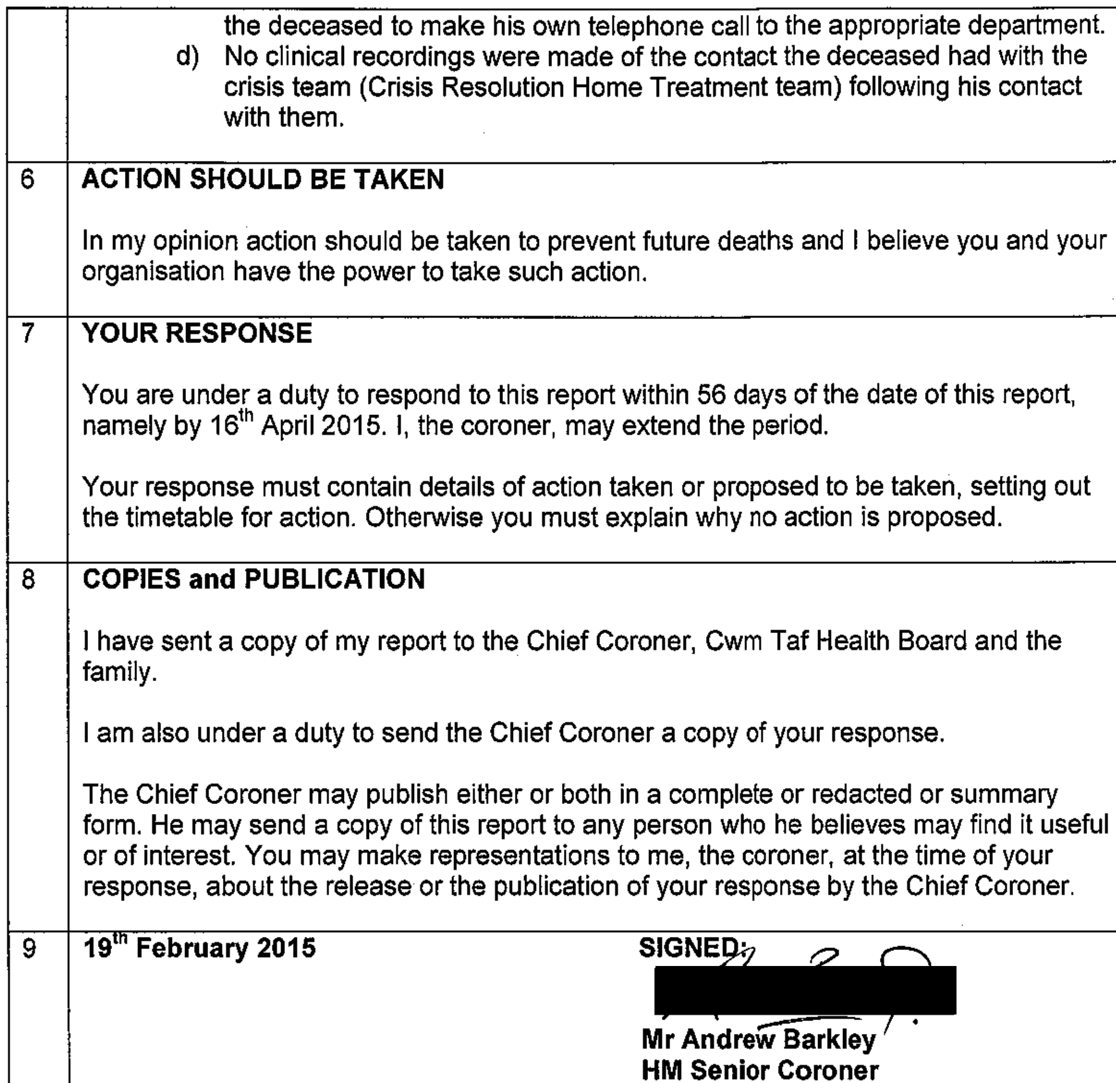
ANNEX A

REGULATION 28: REPORT TO PREVENT FUTURE DEATHS (1)

*NOTE: This form is to be used **after** an inquest.*

	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO:** 1. **Chief Executive of Cwm Taf Health Board** 2. **Chief Coroner** 3. [redacted] **(Partner)**
1	**CORONER** I am Andrew Barkley, Senior Coroner, for the coroner area of Powys, Bridgend and Glamorgan Valleys
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 9th September 2014 I commenced an investigation into the death of Barrie Lewis. The investigation concluded at the end of the inquest on the 18th February 2015. The conclusion of the inquest was "suicide".
4	**CIRCUMSTANCES OF THE DEATH** The deceased was found by his family hanging in a garage at the rear of his property on the morning of the 31st August 2014. He was hanging from a rope attached to a rafter within the garage.
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. – [BRIEF SUMMARY OF MATTERS OF CONCERN] (1) A clinical review was undertaken of the contact the deceased had with the mental health services in the days prior to his death and it was apparent from that review, and from the evidence heard that: a) That no risk assessment was undertaken to detail risks specifically associated with the deceased's suicidal ideation which, on the evidence, would have assisted the crisis team in assessing his risk of suicide or self harm. b) There was little formal mechanism for communication between the mental health out patients department and the acute services which he accessed in the days prior to his death. c) There was no reliable system to ensure that a member of the crisis team took responsibility for providing assistance to the deceased – simply leaving



	the deceased to make his own telephone call to the appropriate department. d) No clinical recordings were made of the contact the deceased had with the crisis team (Crisis Resolution Home Treatment team) following his contact with them.
6	**ACTION SHOULD BE TAKEN** In my opinion action should be taken to prevent future deaths and I believe you and your organisation 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 16th April 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, Cwm Taf Health Board and the family. 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	**19th February 2015** **SIGNED:** **Mr Andrew Barkley** **HM Senior Coroner**