# SOUTH WALES CENTRAL

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| | **REGULATION 28 REPORT TO PREVENT FUTURE DEATHS**<br><br>**THIS REPORT IS BEING SENT TO: Cwm Taf Health Board** |
| 1 | **CORONER**<br>I am Geraint Williams Assistant Coroner for **South Wales Central** |
| 2 | **CORONER'S LEGAL POWERS**<br><br>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.<br>http://www.legislation.gov.uk/ukpga/2009/25/schedule/5/paragraph/7<br>http://www.legislation.gov.uk/uksi/2013/1629/part/7/made |
| 3 | **INVESTIGATION and INQUEST**<br><br>On 23/04/2019 I commenced an investigation into the death of Connor William DAVIES. The investigation concluded at the end of the inquest 29th November 2019. The conclusion of the inquest was On the 13th April 2019 Mr Davies, who had been receiving assistance from Mental Health Services, hanged himself at 11 The Greenways, Maesteg.<br>Cause of death: Hanging, Verdict: Suicide |
| 4 | **CIRCUMSTANCES OF THE DEATH**<br><br>Deceased last had contact with family 10.4.19. He was seen by his grandfather around 0800 hrs 10.4.19. Today, 13.04.19 deceased's brother has decided to look for Connor as he was becoming concerned for his welfare. Brother and mother attended at 11 The Greenway and gone upstairs. Brother has opened a bedroom door to find deceased sat against a wall with a ligature around his neck. His backside was suspended off the floor, hands were in his pockets, his head was slumped to the right and his tongue was sticking out.<br>Brother has shut the door and told his mother to and ring an ambulance. He has then gone back into the bedroom and removed the ligature from around his brother's neck, laid him onto his back on the floor. He felt for a pulse but could not find one. Ambulance crew arrived. |
| 5 | **CORONER'S CONCERNS**<br><br>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.<br><br>The **MATTERS OF CONCERN** are as follows. –<br><br>[BRIEF SUMMARY OF MATTERS OF CONCERN]<br>(1) Mr Davies was seen by a consultant psychiatrist in November 2018 and a follow up appointment made for January 2019. That appointment was cancelled and another made for March 2019. That too was cancelled and a further appointment made for June 2019 but before he could attend Mr Davies killed himself.<br>[redacted] who gave evidence confirmed that when appointments are cancelled there is no clinical input as to the need of individual patients for more urgent referrals and thus a patient who is in serious need of an appointment may 'fall through the net' as may have been the case here.<br>[redacted] told me that he had endeavoured to put in place a system whereby this could be avoided but, to his knowledge, it is not yet operating. |

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| | I recommend that your Trust consider this potential issue as a matter of urgency. |

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| 6 | **ACTION SHOULD BE TAKEN**<br><br>In my opinion action should be taken to prevent future deaths and I believe you Cwm Taf University Local Health board have the power to take such action. |
| 7 | **YOUR RESPONSE**<br><br>You are under a duty to respond to this report within 56 days of the date of this report, namely by 25th January 2020. I, the coroner, may extend the period.<br><br>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**<br><br>I have sent a copy of my report to the family who may find it useful or of interest.<br><br>I am also under a duty to send the Chief Coroner a copy of your response.<br><br>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 | 29/11/2019<br><br>Signature (electronic)<br><br>Geraint Williams Assistant Coroner **South Wales Central** |