REGULATION 28: REPORT TO PREVENT FUTURE DEATHS (1)

	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO:** Chief Constable, North Wales Police, Glan y Don, Abergele Road, Colwyn Bay Chief Executive 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 28th of December 2011 I commenced an investigation into the death of Andrew Selwyn Roberts (DOB 16.5.1979, DOD 25.12.2011). The investigation concluded at the end of the inquest on the 17th of August 2015 when the jury returned a majority narrative conclusion in respect of the death in the following terms :- It is more likely than not that Andrew Selwyn Roberts intended to suspend himself and it is more likely than not that he intended to kill himself but we cannot be sure of his intention. The Medical Cause of Death was recorded as 1(a) Asphyxia by Hanging
4	**CIRCUMSTANCES OF THE DEATH** The Circumstances of the death are that the Deceased was arrested by North Wales Police on the 24th of December 2011 in relation to an offence of threatening behaviour contrary to section 4 of the Public Order Act. He had been tazered in the course of his arrest and it was also known that he had taken an overdose and he was therefore taken from custody at St Asaph to the Emergency Department at Glan Clwyd Hospital. At hospital he was assessed and it was deemed he was fit to be returned to custody. The custody nurse then telephoned the emergency department to request a transfer of care form which was completed by a nurse within the department and faxed back to her. This form inaccurately reported that the Deceased had been seen "assessed by psychiatric liaison who doesn't feel he has genuine mental health issues.." He had in fact not been seen by anyone from the Psychiatric Liaison Team

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. That the Transfer of Care Form was not completed by the Doctor who had carried out the examination of the patient and the information contained therein was subsequently found to be inaccurate. 2. That the Transfer of Care Form was not completed at the time of examination and provided to the Police Officers escorting the detained person to hospital so that it could be returned with them to custody and made immediately available to the custody nurse.
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 15th October 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 legal representatives of the following Interested Persons – The Family of The Deceased, [redacted] (Force Medical Examiner) 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] 20th August 2015 [SIGNED BY CORONER]**