Regulations 28 and 29 of the Coroners (Investigations) Regulations 2013

REGULATION 28: REPORT TO PREVENT FUTURE DEATHS

	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS THIS REPORT IS BEING SENT TO: 1. [redacted] Practice Manager at The Medical Centre, Cardiff Road, Taff's Well, CF15 7YG
1	**CORONER** I am **Caroline Saunders,** Senior Coroner for the Area of Gwent
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 4/12/2020 an investigation was opened into the death of **Siwan Llio SMITH** The investigation concluded at the end of the inquest on: **9/9/2021** The conclusion of the inquest was recorded as: **Suicide** The medical cause of death was: **1a) Suspension by ligature**
4	**CIRCUMSTANCES OF THE DEATH** Siwan Smith had a long-standing history of anxiety and depression which was exacerbated during the Covid 19 pandemic. Siwan's mental health deteriorated and she started to have suicidal thoughts. Siwan did not have ongoing support from either primary or secondary mental health services. On 23rd November 2020 Siwan became overwhelmed by her anxieties and took her own life by hanging at her home address.

5	**CORONER'S CONCERNS** During the course of the inquest, 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. <u>Response to Mental Health Concerns by Reception Staff</u> During the course of the inquest, Mr Martin Smith, Siwan's husband, raised concerns that on 18th November 2020, Siwan telephoned the Medical Centre to obtain an urgent appointment with a doctor. She was informed by the receptionist that the earliest appointment was on 30th November 2020. The Medical Centre provided me with a report which indicated that when Siwan asked about whether there were any emergency appointments for mental health problems she was advised that these are not routinely offered unless a patient is having "bad thoughts". Your report states that an emergency appointment was not requested and at no point was it suggested the call was a mental health emergency. The Medical Centre provided me with a recording of the telephone exchange between Siwan and the receptionist. I found during the inquest that Siwan asked repeatedly if she could have an earlier appointment and was clearly upset that she could not. She was not asked if she was having bad thoughts or whether she required urgent mental health support. It was clear towards the end of the conversation that Siwan was distressed. I also received in evidence a letter dated 8 March 2021 written By [redacted], the Practice Manager to Mr Smith, in which she implies that the receptionists are not clinically trained to make assessments. I accept this, however in the circumstances I determined that Siwan should have received a call back from someone who was clinically trained to ascertain whether she required an urgent mental health assessment. In the circumstances I did not find that a different course of action would have prevented Siwan's death or would have altered the outcome. However I am concerned that lives could be put at risk in the future if there continues to be a lack of awareness of when a patient may require a clinical assessment in relation to their mental health.
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. <u>I should be grateful if the following information be provided to me:</u>

	1. Confirm whether any steps have or will be taken to escalate calls to clinical staff in the circumstances described.
7	**YOUR RESPONSE** You are under a duty to respond to this report within 56 days of the date of this report, namely **04/11/2021**, I, the Coroner, may extend this 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 necessary.
8	**COPIES AND PUBLICATION** I have sent a copy of my report to the Chief Coroner and the following Interested Person (s) • [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 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 14/9/21** Signed  Caroline Saunders **Her Majesty's Senior Coroner for the Area of Gwent.**