## REGULATION 28: REPORT TO PREVENT FUTURE DEATHS

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| | **REGULATION 28 REPORT TO PREVENT FUTURE DEATHS**<br><br>**THIS REPORT IS BEING SENT TO:**<br><br>Chief Executive, BCUHB, Ysbyty Gwynedd, Penrhosgarnedd, Bangor, Gwynedd LL57 2PW |
| 1 | **CORONER**<br><br>I am JOHN ADRIAN GITTINS, senior coroner, for the coroner area of North Wales (East and 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. |
| 3 | **INVESTIGATION and INQUEST**<br><br>On the 16th of June 2015 I commenced an investigation into the death of Christopher Glyn Jones (DOB 6.7.88, DOD 11.6.15). The investigation concluded at the end of the inquest on the 2nd of September 2016 and I recorded a narrative conclusion in the following terms :-<br><br>"Christopher Glyn Jones was a twenty seven year old man who was suffering from a mental illness for which he was receiving care and treatment from the Betsi Cadwaldr University Health Board.<br><br>Although the individual care provided to him by members of staff reflected their desire to act in his best interests, his overall treatment was unsatisfactory due to delays in the formulation of treatment plans and risk assessments and failures in the provision of intended treatments and inadequate escalation of concerns at a time of significant decline in his mental health, although it cannot be said, even on the balance of probabilities, that this resulted in his death which was due to a deliberate act of self harm" |
| 4 | **CIRCUMSTANCES OF THE DEATH**<br><br>The Circumstances of the death are that the deceased died as a result of placing himself into collision with a train whilst under the care of the Community Mental Health Team |
| 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. |

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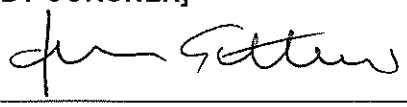
| | The **MATTERS OF CONCERN** are as follows :-<br><br>1. Evidence at the inquest indicated that the deceased was discharged from inpatient treatment on the 6th of January 2015 but his Care Treatment Plan was not completed until the end of April 2015 and that this would then only require review within a period of twelve months from that date, as a result it could have been the case that a patient who had recently been sectioned and treated as an inpatient may not then be seen by a consultant psychiatrist for a period in the region of sixteen months.<br><br>2. Furthermore evidence indicated that although additional resources were currently being made available and deployed for Mental Health within BCUHB, there was also an increasing demand on the service and as a result there may still be deficiencies of service, for example in providing acceptable levels of cover for staff at times of sickness/holidays etc.<br><br>. |
| 6 | **ACTION SHOULD BE TAKEN**<br><br>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**<br><br>You are under a duty to respond to this report within 56 days of the date of this report, namely by 2nd November 2016. 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 Chief Coroner and to the following Interested Person – Leigh Day Solicitors (Representatives of the family of the deceased)<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 | **7th September 2016 [SIGNED BY CORONER]**<br>  |