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:** **Powys Teaching Health Board** **Powys County Council**
1	**CORONER** I am Graeme Hughes, Senior Coroner, for the coroner area of South Wales 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 10th June 2019, I commenced an investigation into the death of Samuel Joseph GOMM. The investigation concluded at the end of the inquest on 18th May 2022. The conclusion of the inquest was Suicide. The medical cause of death was: - 1a. Laceration to neck
4	**CIRCUMSTANCES OF THE DEATH** These were recorded as: - Samuel Joseph Gomm suffered from chronic mental ill health exacerbated by periods of alcohol abuse. On 3.6.19 whilst at home at [redacted], he has deliberately self-inflicted a number of lacerations to his neck. These have led to acute blood loss and his death. It is more likely than not, that he intended the consequences of his actions to be his own death. The Inquest focused upon: - a. The direct circumstances leading to his death. b. The role that Mental Health & Local Authority Services took in the management of his risk of self-harm in the months preceding his death & whether such management may have contributed to his death. I recorded no findings in relation to such management, which were directly causative of his death.

5	CORONER'S CONCERNS At the conclusion of the Inquest, I directed written submissions from the three Interested Person's as to whether my duty under Regulation 28 was engaged & if so, in respect of which matters. I have received & considered the same. 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) The assessment of Sam's risk of self-harm was recorded by his care-co-ordinator in a Wales Applied Risk Research Network (WARRN) assessment tool in March 2019. This form of assessment was adopted by the Integrated Mental Health Services (Powys County Council & Powys Teaching Health Board) in Powys. I also received evidence that it is used throughout Wales by similar services. (2) The evidence I received indicated that the WARRN assessment documentation/tool could be routinely accessed, updated & revised by the Integrated Team. It was a *fluid* document for the purpose of recording information as to the current assessment of risk(s) of self-harm & how that risk(s) was to be mitigated. Whilst I received evidence that in practice, such risk assessments were being undertaken with Sam, the WARRN documentation did not necessarily reflect that, nor was it optimally viewable in terms of clearly recording fluctuating presentations & any accompanying re-assessment of risk. (3) It appeared to me that the format/layout of the WARRN tool, its accessibility, & in particular, its ability to provide a user with clear & easily viewable information as to how Sam's risk of self-harm had fluctuated/altered/changed in the months preceding his death, could lead to important information/assessments being *lost* to a new/infrequent user. This, for example, might be a new care co-ordinator (as in Sam's case), Crisis Team/Community Nurse, or clinician not previously involved with Sam. (4) Given the variety of services involved in Sam's care, this central document, addressing & recording fluctuating risk appeared to me to be a crucial document in the recording of **current** risk (my emphasis). The ability of those charged with Sam's care to view those fluctuations might be hampered by the current presentation of/access to such information. That could lead to an under-estimation of the current risk & sub-optimal mitigating measures being put in place. (5) The WARRN assessment tool might also benefit from a greater degree of interaction between it & the user. For example, it was clear, on the evidence that Social Worker's, Mental Health Nurses & Clinicians were all busy addressing the needs (& assessing risk) of a wide number & variety of patients. **Prompting** (my emphasis) the user to consider & record referrals for, for example, to advocacy services & for capacity assessments might optimise the benefits of the tool & reduce the risk of such opportunities being missed/un-recorded. Such then leading to the potential absence of key information for new/infrequent users when assessing risks of self-harm It may well be helpful (given the Integrated Services approach to Mental Health Services in Powys) if I were to receive one jointly prepared response from both organisations to whom this Report has been sent.

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 26th July 2022. 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 family who may find it useful or of interest. [redacted] [redacted], Minister for Health & Social Services 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	1st June 2022 **SIGNED:** Graeme D Hughes, Senior Coroner for **South Wales Central**