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. The Chief Executive of Aneurin Bevan University Health Board (ABUHB)
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 2/9/2021 an investigation was opened into the death of **Gareth WILLIAMS** The investigation concluded at the end of the inquest on: **17/8/22** The conclusion of the inquest was recorded as: **Suicide** The medical cause of death was: **1a) Suspension by ligature** **2 Tinnitus**
4	**CIRCUMSTANCES OF THE DEATH** Gareth Williams was a 45-year-old man who had a history of sensorineural hearing loss and intermittent tinnitus dating back to 2005. He was also treated for depression and insomnia. In early 2021 the situation deteriorated. Gareth's tinnitus worsened but despite being thoroughly examined by the ENT team there was no physiological problem that could be treated.

	As a result, Gareth's mental health went into decline. He suffered worsening depression and was referred to the mental health team after he started having suicidal thoughts and indeed acting these out. Written evidence from the Consultant Psychiatrist treating Gareth, stated Gareth was not clinically depressed, although evidence also indicated that he had low mood, was expressing hopelessness and experienced suicidal thoughts. Gareth was discharged from the mental health team because he had no recognisable mental illness. On 23/8/21, Gareth was discovered hanging [redacted] in Abergavenny. Emergency services attended but Gareth could not be revived. His death being confirmed at 15:27 hours.
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: - Gareth Williams found himself in a no-win situation. His mental health could not be improved without a resolution to his hearing problems and his tinnitus was untreatable. During the course of his treatment, Gareth was regularly transferred back to the "other" team, being told that either mental health or ENT was the most appropriate speciality. I found that Gareth was left without sufficient support, falling between 2 teams, who did not directly communicate with each other.
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> Whether Aneurin Bevan University Health Board intend to undertake a review into the circumstances surrounding the death of Gareth Williams and confirm the steps which will be taken to ensure that there is better interdisciplinary working between physical and mental health specialities in the future.
7	**YOUR RESPONSE** You are under a duty to respond to this report within 56 days of the date of this report, namely by 25/10/22. 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) The family of Gareth Williams 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 31/08/22** Signed  Caroline Saunders **Her Majesty's Senior Coroner for the Area of Gwent.**