Sarah Olga Riley, Assistant Coroner for North West Wales

	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO:** **Interim Chief Executive of Betsi Cadwaladr University Health Board, Gill Harris**
1	**CORONER** I am Sarah Riley, Assistant Coroner for North West Wales
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. http://www.legislation.gov.uk/ukpga/2009/25/schedule/5/paragraph/7 http://www.legislation.gov.uk/uksi/2013/1629/part/7/made
3	**INVESTIGATION and INQUEST** On the 12th October 2021, I commenced an investigation into the death of Mr Twm Bryn, aged 21. The investigation concluded at the end of the inquest on the 15th February 2023.
4	**CIRCUMSTANCES OF THE DEATH** Mr Twm Bryn died on the 4th October 2021 in a shipping container located near his home address having suspended himself by the neck with a ligature. Mr Twm Bryn had experienced mental health difficulties, including anxiety and low mood since the age of 17. Mr Bryn was referred to Gwynedd Mental Health services after a telephone consultation with his GP on the 26th July 2021. Due to the presence of low mood and anxiety, the referring Dr requested a routine assessment and possibly counselling. Mr Bryn lived with family, had good friends and a job that he liked. The referral outlined low mood for a "few" years with a deterioration in the last "few" months which included feelings of panic, tiredness, poor sleep and appetite with no reported use of illicit substances or excessive alcohol consumption. The referral indicated that Twm Bryn described to the GP feelings "hitting him like a wall" when upset and angry, and at times, thoughts of wanting to harm himself and occasional suicidal thoughts. An appointment with the Local Primary Mental Health Support Service ("LPMHSS") was arranged and took place, via telephone assessment, on the 7th September 2021, 40 days after Mr Bryn was seen by the GP (not within the 28 day target set by the Mental Health Measure). The assessment indicated the presence of long-term low mood accompanied by anxiety, poor sleep and appetite. He was assessed as a mild risk of suicide, and no risk of harm to others with no legal/forensic risk. Mr Bryn was not at risk of abuse in his personal relationships nor at home and no safeguarding concerns were identified. The primary care assessment was discussed at an Allocation meeting on the 13th September 2021 where a decision was made to offer counselling with the Local Primary Mental Health Support Service. There was a waiting list of several months for the said counselling and save for services to which he would need to self-refer, no interim contact, monitoring or support was discussed or offered to Mr Bryn. Mr Bryn died before counselling was made available to him.

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. – [BRIEF SUMMARY OF MATTERS OF CONCERN] (1) Continued staffing pressures within Primary Mental Health Services resulting in assessment delays and waiting lists for support e.g the waiting list for LPMHSS counselling remains at 4 – 6 months. There was no evidence that the waiting list would improve moving forward (2) Whilst awaiting counselling, the only interim support available to patients that are assessed as mild or low risk, are services that come with a requirement to self-refer, despite lack of motivation being a common symptom. The LPMHSS does not have a standardised process for referring low risk patients for interim support and no interim contact or monitoring is offered or arranged (unless patients have self-referred to an organisation providing such services).

6	**ACTION SHOULD BE TAKEN** In my opinion action should be taken to prevent future deaths and I believe you (and/or 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 14th April 2023. 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 following Interested Persons, [redacted] (mother) I am also under a duty to send a copy of your response to the Chief Coroner and all interested persons who in my opinion should receive it. 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	Dated 17 February 2023  Signature_____ for North West Wales