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:** The Chief Executive of Swansea Bay University Health Board (Mark Hackett), One Port Talbot Gateway, Baglan Energy Park, Port Talbot, Sa12 7BR
1	**CORONER** I am Kirsten Heaven, Assistant Coroner, for the coroner area of SWANSEA NEATH & PORT TALBOT
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 13th May 2019 an investigation was commenced into the death of Samuel Alexander Morgan who was found deceased in his parents' house on the 9th May 2019 after having tied a ligature around his neck. He was 29 years of age at the time of his death. The investigation concluded at the end of the inquest on 6th March 2023. The medical cause of death was: 1a Hanging
4	**CIRCUMSTANCES OF THE DEATH** The deceased was Samuel Alexander Morgan At the time of his death Samuel was suffering from alcohol addiction and had a diagnosis of ADHD and social anxiety. Prior to his death Samuel had received treatment from the Community Drug and Alcohol Treatment ('CDAT') team and primary mental health services. Samuel was discharged from CDAT fifteen months prior to his death. CDAT had information on their system (including from their own risk assessment) to indicate that Samuel had been assessed as a significant risk of suicide. There was other valuable information about Samuel's risk factors on the CDAT system. At the time when Samuel was under CDAT the GP had also referred Samuel to the community mental health team raising his concerns about Samuel's risk of suicide. It is not clear is CDAT had access to this letter. When the primary mental health services consultant began treating Samuel for his ADHD - which continued up to Samuel's death - he received a referral from CDAT but he did not have access to the detailed information on the CDAT electronic system. The consultant could not and did not see the CDAT risk assessment, the outcome and assessment from the individual CDAT sessions and other vital historical information of potential relevance to Samuel's risk factors and triggers for suicide.

5	**CORONER'S CONCERNS** During the inquest the evidence revealed matters giving rise to a 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 make a report under paragraph 7, Schedule 5 of the Coroners and Justice Act 2009 and Regulations 28 and 29 of the Coroners (Investigations) Regulations 2013 The first **MATTERS OF CONCERN** is as follows: I am concerned that in cases where an individual is receiving treatment from alcohol and drug addiction services and treatment from the primary community mental health team that neither team is able to access the other teams records electronically. The lack of integrated electronic records between treating team means that important information regarding patient safety is not easily accessible between treating teams. Treating teams are reliant on referral letters which are necessarily limited and not always sufficient to capture all the detailed information available to a referring team. This is particularly concerning where there is dual diagnosis - such as substance misuse and mental health - given these are often complex cases. This is particularly the case where complex cases have not been referred into secondary mental health services and so do not have access to a care-coordinator who can oversee and understand the views of the various professionals treating and assisting an individual. I am concerned that the lack of such an integrated electronic system of medical and treatment records inhibits the effective sharing of information regarding patient safety and so increases the risk that information of significance regarding a risk to life will be lost between agencies and not sufficiently understood between all those managing risk.
6	ACTION SHOULD BE TAKEN In my opinion action should be taken to prevent future deaths and I believe 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 13 July 2023. I, as 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, Swansea Bay University Health Board and Samuel's family. 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	18 May 2023