John Adrian Gittins
Senior Coroner for North Wales (East and Central)

	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO:** BCUHB, Ysbyty Gwynedd, Penrhosgarnedd, Bangor, Gwynedd LL57 2PW.
1	**CORONER** I am John Adrian Gittins, Senior Coroner for North Wales (East and 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 the 28th of March 2022 I commenced an investigation into the death of Andrew John Shambrook (DOB 17.2.77 DOD 27.3.22). The investigation concluded at the end of the inquest on the 28th of April 2023. The cause of death was recorded as being due to 1(a) Hanging and the conclusion of the inquest was that of suicide. The evidence indicated that Mr Shambrook was under the care of the mental health services and that there had been a referral to the Home Treatment Team, however he did not meet their criteria for treatment.
4	**CIRCUMSTANCES OF THE DEATH** The circumstances of the death are that Mr Shambrook took his own life by hanging [redacted] on the 27th of March 2022.
5	**CORONER'S CONCERNS** During the course of the inquest the evidence revealed the following matter 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 **MATTER OF CONCERN** is as follows. – The health board (by their own admission through counsel) acknowledge that there is no documented or robust policy in relation to decision making/meeting criteria and thereafter future treatment and care pathways when a patient is referred to the Home Treatment Team
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.

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 of July 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 Family of the Deceased and to the Chief Coroner. 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	Dated 31st May 2023  Signature, Senior Coroner for North Wales (East and Central)