Kate Robertson
Assistant Coroner for North Wales (East and Central)

	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO:** Betsi Cadwaladr University Health Board (BCUHB)
1	**CORONER** I am Kate Robertson, Assistant 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 30 March 2023 an investigation was commenced into the death of Richard Geraint Griffiths (DOB 12/1/70) who died on 26 March 2023. The investigation concluded at the end of the inquest on 14 September 2023. The conclusion of the inquest was suicide.
4	**CIRCUMSTANCES OF THE DEATH** The circumstances of the death are as follows :- Richard Griffiths moved home to the Conwy area from South Gwynedd in October 2022 to live with his mother. He was under the care of the South Gwynedd Community Mental Health Team. For reasons unknown the transfer of care did not occur. Sadly, on 26 March 2023 he was found suspended [redacted]. Once he was found he was cut down and the emergency services were also called. He was pronounced deceased at the location.
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 –

	a. The Investigation undertaken by the Health Board was deficient in that it did not contain pertinent points relating to how the transfer of care did not occur. I have previously issued a number of Prevention of Future Death Reports relating to quality and timeliness of investigation. b. The Health Board's Transfer of Care document at the time the transfer occurred did not include any detail or process as to how the transfer should occur. The amended policy has still not been finalised and there remains a concern that deaths will continue to occur if the process is not finalised and shared widely within the Health Board to staff. c. Patient notes for mental health are still not electronic; they are paper based. I have issued several Prevention of Future Death Reports specifically relating to this. There has been considerable delay in actioning this and yet there is still not anticipated timescale for this to occur. As such, deaths will continue to occur or may occur into the future with the risk that notes are paper based only. The risk relates to only one department or individual having access to them at once when there is wider support for the patient.
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 9 November 2023. I, Kate Robertson, 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, to the Chief Coroner and to [redacted], Health Minister. 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 14 September 2023

	 Signature Assistant Coroner for North Wales (East and Central)