GRAEME HUGHES

HIS MAJESTY'S SENIOR CORONER

SOUTH WALES CENTRAL CORONER AREA

CORONER'S OFFICE
THE OLD COURTHOUSE
COURTHOUSE STREET
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CF37 1JW

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ANNEX A

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 Cardiff & Vale University Health Board**
1	**CORONER** I am **Andrew Morse H M Coroner**, for the coroner area of South Wales 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 October 2023 I commenced an investigation into the death of Robert Maxwell SMITH . The investigation concluded at the end of the inquest 07/05/2025 . The conclusion of the inquest was Suicide. **1a Pressure On Neck, Consistent With Hanging** **1b** **1c** **II**
4	**CIRCUMSTANCES OF THE DEATH:**

	These were recorded as follows Robert Maxwell Smith died on 26th October 2023 at [redacted], Cardiff. Mr Smith died by hanging [redacted]. It is more likely than not that he intended the consequences of his action to result in his own death. Mr Smith had recent contact and intervention from mental health services and was known to be at risk of suicide due to a deterioration in his mental health presentation over the preceding weeks. Mental heath services did not inform Mr Smith's wife of the extent of his suicidal ideations. Mr Smith had indicated that he would inform his wife of his raised suicidal ideations but did not do so. On balance, it cannot be said that if such information had been provided, Mr Smith's suicide would have been prevented. Conclusion: Suicide
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. 1. The guidance provided to clinicians and nursing staff within the mental health services as to when information and sharing and information gathering was to be undertaken with, and from, family members and how such decisions are to be recorded on the standard forms lacked clarity, particularly as regards the distinction between information sharing and information gathering. Such guidance being of relevance when a patient has given consent for information sharing and gathering to take place and when, and in what circumstances, such steps would be taken. 2. The information leaflet provided to patients lacked sufficient detail of the approach taken by mental health services on the issue of information sharing and information gathering so that patients could readily understand the difference between the two and understand when the need for information sharing and/or gathering could arise and what steps would be taken by mental health services.
6	**ACTION SHOULD BE TAKEN** In my opinion action should be taken to prevent future deaths and I believe you and 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 16th July 2025. Only 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 family who may find it useful or of interest. Health inspectorate Wales, Welsh Government, 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	21 May 2025 **SIGNED:**  Andrew Morse H M Coroner for South Wales Central Coroner Area