



Regulation 28: REPORT TO PREVENT FUTURE DEATHS

NOTE: This form is to be used **after** an inquest.

	REGULATION 28 REPORT TO PREVENT DEATHS THIS REPORT IS BEING SENT TO: 1 Chief Executive Of Monmouthshire County Council 2 Managing Director Of Mj Events
1	CORONER I am Caroline SAUNDERS, Senior Coroner for the coroner area of Gwent
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 18 October 2024 I commenced an investigation into the death of Marc Daniel DAVIES aged 45. The investigation concluded at the end of the inquest on 10 October 2025. The conclusion of the inquest was recorded as: Drug Related death The medical cause of death was: 1a) The combined toxic effects of methadone, clonazepam and nitrazepam The conclusion of the inquest was that: Marc Daniel Davies died at the Huntsman Hotel in Shirenewton, Chepstow on 16/10/2024 from the toxic effects of prescribed and unprescribed drugs.
4	CIRCUMSTANCES OF THE DEATH Marc Daniel Davies resided at the Huntsman Hotel in Monmouthshire. The accommodation, for people who are vulnerable and homeless, was provided by Monmouthshire County Council (MCC). On 16/10/2024, the safe guards on duty were alerted to concerns raised by friends of Marc, that he was unwell. On checking Marc, the guards noted he was not conscious but thought he was sleeping and put him in the recovery position. They did not conduct routine welfare checks thereafter, did not record the findings of their checks and did not seek medical assistance. Marc was later discovered moribund by another resident. The safeguards performed CPR and called the emergency services. Marc could not be revived and died on 16/10/2024 at the Huntsman Hotel.
5	CORONER'S CONCERNS During the course of the investigation my inquiries revealed matters giving rise to concern. In my opinion there is a risk that future deaths could 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) MCC contracted with MJ Events to provide safe guards; officers to ensure the security of the premises and the welfare of the residents. The officers were expected to undertake welfare checks if they had concerns about residents, including if they were under the influence of drugs or alcohol. Managers from MCC and MJ Events who gave evidence to the inquest both agreed the welfare checks undertaken by the guards on duty on 16/10/2024, and documentation completed, were inadequate. There was no evidence that the staff had received training on how to conduct welfare checks or what should be documented. A failure to check on the welfare of staff and to reliably pass that information on to others could again result in a resident not receiving medical care in a timely manner. Kindly advise me as to the training that you intend to provide to staff to ensure that they are properly equipped with the skills to discharge their duties at work.
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 December 15, 2025. 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 Family Members And Next Of Kin I have also sent it to Not Applicable . who may find it useful or of interest. 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. I may also send a copy of your response to any person who I believe may find it useful or of interest. 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: 20/10/2025  Caroline SAUNDERS Senior Coroner for Gwent