Bwrdd Iechyd Prifysgol
Hywel Dda
University Health Board

Swyddfeydd Corfforaethol, Ail Lawr, Bloc C.
Adeiladau'r Llywodraeth, Heol Picton,
Caerfyrddin, Sir Gaerfyrddin, SA31 3BT

Corporate Offices, Second Floor, Block C,
Government Buildings, Picton Terrace,
Carmarthen, Carmarthenshire, SA31 3BT

[redacted]

Dyddiad/Date:6th July 2026

Mr Gareth Lewis
Senior Coroner for Carmarthenshire and Pembrokeshire
Coroner's Office
North Wing, County Hall
Haverfordwest
SA61 1TP

Dear Mr Lewis

Response to the Report to Prevent Future Deaths issued on the 11th May 2026

Thank you for your correspondence dated 11th May 2026 concerning the above matter. I am writing on behalf of Hywel Dda University Health Board in response to the issues raised and to outline the actions taken and planned.

The Health Board would like to thank the Coroner for bringing these matters of concern to our attention. We have carefully considered the findings arising from the inquest and sincerely acknowledge the concerns expressed regarding the quality of mental health risk assessment undertaken in this case and the need to ensure that practitioners adopt a collaborative, professionally curious and information-seeking approach when undertaking assessments.

The Health Board accepts that effective risk assessment relies upon the gathering, consideration and formulation of information from multiple sources and should not rely solely on information provided by the referrer or by the individual being assessed. We recognise the Coroner's concern that an over-reliance on referral information could result in incomplete assessments and we are committed to ensuring our systems, training and culture support robust multi-agency information gathering and risk formulation.

Actions already implemented
Since the death of Mr Evans, the Health Board has implemented a number of improvements designed to strengthen information gathering, risk assessment and inter-agency communication.

1. Introduction of referral and assessment support tools

A Comprehensive Assessment Tool has been introduced that requires practitioners to consider multiple sources of information, including historical and collateral information where available. The assessment includes prompts to seek information from family members, carers and other relevant sources, where appropriate and in line with consent, confidentiality and safeguarding requirements. This supports a more holistic understanding of an individual's presentation, circumstances and risks, and ensures collateral information is routinely considered in assessment, risk formulation and decision-making. The tool also enables practitioners to record the information sources used and any attempts made to obtain collateral information when it is unavailable.

An aide memoir has been implemented to support practitioners in systematically gathering key information when receiving referrals for mental health assessment. This tool supports practitioners to obtain and document relevant information required to inform assessment and risk formulation.

2. Strengthened coordination and information sharing

The Health Board has established an Out of Hours Clinical Coordinator service operating 24 hours a day, seven days a week. This role acts as a central point of contact across agencies and helps facilitate communication, coordination and information sharing between services involved in urgent mental health care.

In addition, twice-daily bed management and operational coordination meetings are undertaken involving Mental Health Services, Approved Mental Health Professionals (AMHPs) and Police representatives. These meetings provide a structured opportunity for real time information sharing, discussion of current risks and coordination of responses across agencies. This arrangement was introduced since the death of Mr Evans and has strengthened collaborative working between partner organisations.

Closer operational links have also been established between Mental Health Services and Dyfed-Powys Police through the Clinical Coordinator function and out-of-hours arrangements. Police officers regularly seek advice and support from this function, including consultation regarding Mental Health Act Section 136 matters. These contacts, discussions and clinical considerations are documented within the clinical record where relevant to support continuity of care and risk management.

Furthermore, the implementation of NHS 111 Press 2 for Mental Health provides a single point of access for service users, families and carers seeking urgent mental health advice and support. The service facilitates timely access to mental health professionals and enables navigation and signposting across the wider mental health system, improving opportunities for early intervention, access to support and information sharing.

3. Safety planning and formulation-based practice

The Health Board has implemented a person-centred safety planning approach across services, initially within inpatient settings and now extending into community services. The approach supports collaborative assessment and management of risk through active engagement with service users and their support networks.

4. Workforce development through WARRN

The Health Board continues to deliver Wales Applied Risk Research Network (WARRN) training across mental health services. WARRN promotes a formulation-based approach to assessment and specifically emphasises:

- gathering information from multiple sources
- reviewing clinical records and historical information
- seeking information from family members, carers and partner agencies where appropriate
- avoiding reliance solely on an individual's account
- multidisciplinary decision-making
- documenting information sources and information sharing activities
- ensuring risk assessment is linked to risk management and safety planning.

The training explicitly promotes professional curiosity, collaborative working and shared responsibility for risk assessment and management.

Immediate actions taken following the Coroner's Inquest

Following the Coroner's Inquest, additional immediate actions have been undertaken.

1. Reinforcement of expectations regarding historical information review

A formal professional practice reminder has been issued to all relevant mental health practitioners, medical staff and psychiatrists requiring them to review electronic patient records (Care Partner) prior to undertaking assessments. The instruction reminds staff that they must actively consider:

- previous service involvement
- documented risks
- historical clinical information
- relevant safeguarding and clinical concerns.

The communication emphasises that failure to review available historical information may result in incomplete assessment and increased clinical risk.

2. Team discussions and practice reinforcement

The requirements regarding review of historical information and consideration of collateral information have been discussed within operational team meetings across Adult Mental Health Services to reinforce expectations and support consistent practice.

3. Review of partnership information-sharing arrangements

Work is underway with police colleagues to strengthen understanding and use of existing police handover processes within Pembrokeshire, ensuring important information is available to clinicians undertaking assessments when police have had recent involvement with an individual.

4. Strengthening the duty practitioner role

The Health Board has commenced work to strengthen expectations regarding the role of duty practitioners undertaking urgent assessments, including clarification that assessment responsibility extends beyond analysing information presented and includes seeking additional collateral information where necessary to ensure a robust assessment.

Further actions planned

The Health Board recognises that the Coroner's concern extends beyond policy and procedure and relates fundamentally to professional culture, clinical practice and the approach taken to risk assessment.

Independently of, and prior to, the Prevention of Future Deaths Report, the Health Board had already been actively engaged in a national programme of work aligned to the Open Access Mental Health Support Model, focused on strengthening approaches to risk, safety and system-wide responsibility for managing risk. This work reflects emerging national policy and best practice and was established before the conclusion of the inquest.

A central aim of this programme is to support a shift from traditional models in which responsibility for risk management can be perceived to rest primarily with an individual practitioner, towards a culture of shared safety, professional curiosity, collaborative assessment and collective responsibility across services, agencies, communities and individuals. The Health Board considers that this direction of travel closely aligns with the issues highlighted by the Coroner and provides a strong framework through which these concerns can continue to be addressed.

The Health Board is represented on the programme steering group and will be actively participating in four national workstreams that are currently being established:

1. Shifting the Risk Paradigm and Building a Just Culture
2. Person-Centred Safety and Shared Decision Making
3. Strengths-Based Crisis Response and Suicide Prevention
4. Community and System Leadership for Safety

Implementation of learning and guidance arising from this programme will continue throughout 2026 and 2027 and will be reflected within local policies, workforce development programmes and clinical governance arrangements.

Conclusion

Hywel Dda University Health Board fully accepts the importance of the concerns identified by the Coroner and agrees that risk assessment should be informed by a comprehensive understanding of all relevant information available at the time of assessment.

We believe the actions already implemented, the immediate actions undertaken following receipt of this report, and our ongoing participation in national safety and risk improvement work collectively address the issues identified and support the cultural shift towards collaborative, information-seeking, formulation-based assessment practice described by the Coroner.

The Health Board remains committed to continuous learning and improvement to reduce the risk of future deaths and improve the safety of those accessing mental health services.

Yours sincerely,

Chief Executive Officer