

**REPORT TO PREVENT FUTURE DEATHS
REGULATION 28 OF THE CORONERS (INVESTIGATIONS) REGULATIONS
2013**

Please do not include any living persons' names in this document, in accordance with the Chief Coroner's [PFD Publication Policy \(2026\)](#).

1.	CORONER I am Gareth Lewis, Senior Coroner, for the coroner area of Carmarthenshire and Pembrokeshire.
2.	DATE OF REPORT 11th May 2026
3.	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.	THIS REPORT IS BEING SENT TO 1. Hywel Dda University Health Board You are under a duty to respond to this report within 56 days of the date of this report, namely by 6th July 2026. I, the coroner, may extend the period if an appropriate application is made.
4.	YOUR RESPONSE 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. I have a duty to send a copy of your response to the Chief Coroner. In accordance with the Chief Coroner's Publication Policy, you should send me any representations regarding publication of your response. These representations should be made at the same time as the response is provided. I will pass any representations received to the Chief Coroner for a decision. Please note any links to webpages included in the response will not be checked for sensitive information prior to publication, as the information is already online. The names of those who do not respond to PFD reports are regularly published on the Chief Coroner's webpages Non-responses to Prevention of Future Death (PFD) reports - Courts and Tribunals Judiciary.
5.	SUMMARY OF CORONER'S CONCERN During the inquest I heard evidence which concerns me about the approach taken by those undertaking mental health assessments within the Community

	Mental Health Team. Whilst I have received evidence from the Senior Nurse for Pembrokeshire Adult Community Mental Health Service to say that there is a more robust system in place now (compared to when Trevor died in 2020) and that there is an aide memoir which has been implemented to support practitioners to systematically collate the information required from referrers when receiving referrals for assessment, I still have concerns. The reasons for my concerns are that contrary to the above, I also received evidence during the inquest from a Community Psychiatric Nurse who said: “it’s not my job” to seek out information, “that is the duty of the referrer” and “the Role of the Duty Officer (i.e. the person doing the assessment) is to assess the information not gather it”. Furthermore the evidence of the Senior Nurse for Pembrokeshire Adult Community Mental Health Service was that “The process places emphasis on the referrer to provide a comprehensive and accurate handover. Responsibility for the accuracy and completeness of information provided, particularly in relation to identified or potential risks, rests with the referrer at the time the referral is made.” “There is no explicit requirement for the Community Mental Health Team to proactively seek information from partner agencies at the point of handover, unless the partner agency is the referring service.” For as long as that approach or attitude continues I fear that mental health risk assessments in Pembrokeshire may be incomplete, perfunctory and inadequate. There needs to be a change in culture to a more collaborative approach where those undertaking the assessment adopt a more inquisitive and information seeking style to ensure that as much relevant information as possible is available when undertaking these very important risk assessments. In this particular case, notwithstanding the fact that this was an emergency referral from a GP, the Risk Assessment was completed without knowledge of the significant police and ambulance involvement with Trevor in the preceding week, the fact that a noose had been found at Trevor’s home, his family were very concerned for his mental wellbeing, his previous suicide attempts and his previous involvement with the Crisis Response Home Treatment Team. There was an abundance of relevant information available had the assessor made some basic enquiries. There needs to be a shift of onus to a more collaborative approach so that those undertaking the assessment explore what information is available to them and do not simply rely on the details provided by the referrer. Ultimately, it is the assessors name on the risk assessment and they need to be satisfied that it is a thorough and robust assessment of the risk.
6.	ACTION SHOULD BE TAKEN In my opinion unless action is taken to address the above concerns then there is a significant risk of future deaths and I believe each of you have the power to take such action.

7.	INVESTIGATION AND INQUEST On 28th February 2020 an investigation into the death of Trevor Anthony Evans, aged 54 years, was commenced by the then Senior Coroner, Mark Layton. The investigation concluded at the end of a five-day inquest, heard by me, between 13th April 2026 and 17th April 2026. During the inquest I heard evidence allowing me to make the following findings: The medical cause of death was: Asphyxia by hanging How, when and where: Trevor Anthony Evans died as a result of hanging himself on 27th February 2020 [REDACTED] at his home address of 37 Whitehall Drive, Pembroke in circumstances where he was struggling with his mental health and in the absence of a thorough mental health risk assessment being undertaken. Conclusion: Suicide
8.	CIRCUMSTANCES OF DEATH [Please explain the relevant circumstances of the individual's death, ideally this should be in no more than 500 words] During the inquest I heard evidence on events that occurred during the period 18th February 2020 through to the date of Trevor's passing on 27th February 2020. The evidence focused specifically on Trevor's contact with the police, ambulance service, mental health professionals and health care staff during that period. Trevor was struggling with his mental health during this period and his conduct was such that his family, the police and the ambulance service all had concerns for his mental health which culminated in a GP making an emergency referral for a mental health assessment. On 24th February 2020 Trevor was assessed by a Community Mental Health Nurse. After hearing evidence, I found that there was an over reliance on what Trevor told the nurse, a failure to review medical records and a lack of investigation or scrutiny into an abundance of background information that was available. With hindsight had all of that information which was readily accessible been reviewed then a referral to the Mental Health Crisis Team would have been appropriate. Trevor sadly took his own life on 27th February 2020.
9.	CORONER'S CONCERNS During the course of the inquest I heard evidence 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: [250-word statement addressing what circumstances of the death have led to the coroner's concern, and why the coroner thinks the person to whom the report is directed is responsible for taking action to prevent future deaths. This

	statement must not propose what action should be taken, as coroners cannot make recommendations]. In this case, I found that there was an over reliance on what Trevor told the nurse, a failure to review medical records and a lack of investigation or scrutiny into an abundance of background information that was available. Notwithstanding the fact that I have been told that changes have been made by the Health Board to ensure that those undertaking assessments now look to obtain as much information as possible I also received evidence which indicates that assessors still harbour an attitude that it is the referrer job to provide all the relevant information and then those performing the risk assessment will simply assess the information. For as long as that approach or culture continues I fear that mental health risk assessments in Pembrokeshire may be incomplete, perfunctory and inadequate. There needs to be a shift of onus to a more collaborative approach so that those undertaking the assessment explore what information is available to them and do not simply rely on the details provided by the referrer. It is essential that those undertaking the mental health assessments are aware of the need to obtain as much information as possible in order to complete a full and thorough assessment of the risk and that they are aware of how to and where to obtain the relevant information from.
10.	COPIES AND PUBLICATION OF THIS REPORT I have a duty to send a copy of my report to every Interested Person who in my opinion should receive it. I also may send a copy of the report to any other person who I believe may find it useful or of interest. I can confirm I have sent the report to: <i>[please do not use individual's names, but instead roles/titles]</i> 1. Family of Trevor Anthony Evans 2. Dyfed Powys Police 3. Welsh Ambulance Service Trust I also have a duty to send a copy of the report to the Chief Coroner. You may make representations to me, the coroner, about the publication of the contents of this report in line with Chief Coroner's PFD Publication Policy (2026). Any representations will be sent to the Chief Coroner alongside the report. Please refer to box 4 above for additional information relating to the publication of reports and responses.

	SIGNATURE  Gareth Lewis – Senior Coroner for Carmarthenshire & Pembrokeshire Dated: 11th May 2026
--	--

