REGULATION 28: REPORT TO PREVENT FUTURE DEATHS (1)

	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO:** BCUHB, Ysbyty Gwynedd, Penrhosgarnedd, Bangor, Gwynedd LL57 2PW
1	**CORONER** I am JOHN ADRIAN GITTINS, senior coroner, for the coroner area of 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 the 10th of January 2014 I commenced an investigation into the death of Alun Sheppard (DOB 10.01.1965 DOD 10.01.2014). The investigation concluded at the end of the inquest on the 3rd of June 2014 and I recorded an narrative conclusion in respect of the death in the following terms :- On the 21st of December 2013 at The Fields, Holt, Wrexham the Deceased took a kitchen knife and inflicted upon himself a number of stab wounds. Although he initially survived these injuries and was treated for them, his condition deteriorated resulting in his death at the Maelor Hospital Wrexham on the 10th of January 2014
4	**CIRCUMSTANCES OF THE DEATH** The Circumstances of the death are as set out in the narrative conclusion appearing in paragraph 3 hereof.
5	**CORONER'S CONCERNS** During the course of the inquest, evidence given by the family of the Deceased indicated that although Mr Sheppard had been receiving treatment for a condition diagnosed as Paranoid Psychosis, they were unaware of this true extent of his mental health issues and consequently were unable to fully support Mr Sheppard and to take appropriate steps which may have mitigate the opportunity for him to self harm. 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 :- Effectively the concern in this case revolves around whether the Health Board are able to balance the patient's right to confidentiality whilst also seeking to optimize the prospect of recovery by facilitating familial support.
6	**ACTION SHOULD BE TAKEN** In my opinion action should be taken to prevent future deaths and I believe your organisations 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 8th August 2014 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 Person – [redacted] (brother of the Deceased) 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	**[DATE] 13th June 2014 [SIGNED BY CORONER]**