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:** **1. Chief Executive of Cwm Taff University Health Board** **2. Head of Mental Health at Cwm Taff University Health Board**
1	**CORONER** I am Andrew Roger Barkley, Senior Coroner, for the coroner area of South Wales Central Area.
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 13th June 2017 I commenced an investigation into the death of the David Michael Sewell aged 46. The investigation concluded at the end of an inquest today 6th September 2017. The medical cause of death was 1a. Transection of the left brachial artery and the conclusion of the inquest was "Suicide".
4	**CIRCUMSTANCES OF THE DEATH** The deceased lived on his own and was discovered in the bath at his address in the early hours of the 5th June 2017 by his mother who forced entry to his property. He was found covered in blood with obvious injuries to his arms. He was holding a cut throat shaving razor close to his face with his right hand. He was known to have suffered some form of a breakdown in July and August of 2016 after which he attempted to cut his arms and neck and was admitted to hospital. Upon his release he was under the care of the home treatment team who visited him daily from the 9th to the 14th July. He was reviewed by a Psychiatrist on the 13th July and prescribed medication. He was then re-admitted to hospital on the 2nd August following a mixed overdose and was referred on to see a Psychiatrist within the Community Mental Health Team. He was not seen by a Psychiatrist as planned due to difficulties with appointments. His only other contact with health professionals were with his General Practitioner.
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) When Mr Sewell attended for the appointment with the Psychiatrist he was told by the main reception that they were unaware of a Health Worker of that name and he left the building. He was contacted by telephone on 3 occasions on the 16th and 17th August but displayed hostility towards members of the team. His case was discussed by the Multi-Disciplinary Team on the 18th August 2016 who

	decided to write a letter him which was sent on the 26th August inviting him to make contact or otherwise he would be discharged from the Teams care. He did not respond to that letter and no further follow up was made. The concern the evidence revealed relates to the apparent lack of a robust system to ensure that individuals with mental health problems, who may have experienced psychotic episodes as Mr Sewell had, are seen and appropriate care delivered. It was apparent from the evidence that after the letter was sent inviting him to make contact he was simply discharged from the case load with no further efforts or steps being made to try and re-engage him. There was clearly a need to do so.
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 2nd October 2017. 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, the family and the Minister of Health Welsh Government Assembly who may find it useful or of interest. 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	**7th September 2017** **SIGNED:**