John Adrian Gittins
Senior Coroner for North Wales (East and Central)

	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS THIS REPORT IS BEING SENT TO: BCUHB, Ysbyty Gwynedd, Penrhosgarnedd, Bangor, Gwynedd LL57 2PW Wrexham County Borough Council The Guildhall, Wrexham
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 8th of June 2017 I commenced an investigation into the death of Daniel Watson (DOB 24.6.87, DOD 5.6.2017). The investigation concluded at the end of the inquest on the 8th of December 2017 and I recorded a narrative conclusion in the following terms "On the 5th of June 2017 the Deceased was verified dead at his home address as a result of placing a ligature around his neck, however the evidence does not establish his intention to the necessary legal standard." The cause of death was 1(a) Hanging
4	**CIRCUMSTANCES OF THE DEATH** The Deceased was known to the Flintshire and Wrexham Community Mental Health Teams and had been allocated a social worker on the Wrexham Team on the 7th of December 2016 following a request from his Consultant Psychiatrist following a lengthy delay in the transfer of his care from Flintshire. Focus for his support was on his social/housing needs and there was no evidence of any up to date care and treatment plan nor any evidence of comprehensive risk formulation. During the early part of 2017 a number of social factors resulted in an apparent decline in Daniel Watson's mental health and on the 5th of June 2017 he was found hanged at his home.
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. The Concerns Root Cause Analysis Investigation undertaken by BCUHB revealed a multitude of care and service delivery problems and contributory factors in relation to the care and treatment of the Deceased which cumulatively represented missed opportunities to improve his mental health and the evidence given at the inquest by the social worker and community psychiatric nurse demonstrated a complete lack of understanding and empathy in relation to these issues. 2. That there needs to be a significant improvement in the training of staff within the CMHT in relation to their understanding of risk assessment and potential escalation of concerns towards a formal psychiatric assessment.

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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 5th February 2018 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 – The Family 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	Dated 18th December 2017 Signature  Senior Coroner for North Wales (East and Central)

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