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
1	**CORONER** I am John Adrian Gittins, Senior Coroner for 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 31/03/2015 I commenced an investigation into the death of John William Rogers, (DOB12.7.36 DOD 28.3.15) The investigation concluded at the end of the inquest on 08 March 2016. The conclusion of the inquest was one of Natural Causes, the Cause of Death being recorded as 1(a) Left Ventricular Failure (b) Myocardial Infarction (c) Occlusive Coronary Artery Atheroma
4	**CIRCUMSTANCES OF THE DEATH** The Deceased was admitted to Glan Clwyd Hospital on the 25th of March 2015 and in the early hours of the 28th of March was found collapsed on the floor near to his bed following a cardiac arrest. In the course of the subsequent resuscitation attempts the defibrillator was set on 2 joules rather than the required 150 joules yet although this error was identified by nursing staff after around 30/40 minutes they did not advise the crash team of this. The defibrillator was being controlled at the time of this error by a member of the nursing staff who was operating the machine on a manual setting for the first time and whose Advanced Life Support qualification (obtained more than four years before) had expired the previous month.
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. – That the current systems in place within BCUHB are not sufficiently robust to ensure that their staff are appropriately qualified to undertake the work required of them and that their training and qualifications remain up to date.

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6	**ACTION SHOULD BE TAKEN** In my opinion action should be taken to prevent future deaths and I believe you 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 03/05/2016. 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 legal representatives of following Interested Persons – The Family of the Deceased [redacted] 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 08 March 2016 Signature Senior Coroner for North Wales (East and Central)

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