## REGULATION 28: REPORT TO PREVENT FUTURE DEATHS (1)

| | **REGULATION 28 REPORT TO PREVENT FUTURE DEATHS**<br><br>**THIS REPORT IS BEING SENT TO:**<br><br>Chief Executive BCUHB, Ysbyty Gwynedd, Penrhosgarnedd, Bangor, Gwynedd LL57 2PW |
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| 1 | **CORONER**<br><br>I am JOHN ADRIAN GITTINS, Senior Coroner, for the Coroner area of North Wales (East and Central)] |
| 2 | **CORONER'S LEGAL POWERS**<br><br>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**<br><br>On the 19th of February 2015 I commenced an investigation into the death of Sarah Ann Tyler (DOB 21.4.75, DOD 11.2.2015). The investigation concluded at the end of the inquest on the 12th of January 2017 when I reached a conclusion of an Accidental Death with the cause of death being 1(a) Brain Anoxia due to 1(b) Hanging. |
| 4 | **CIRCUMSTANCES OF THE DEATH**<br><br>The Circumstances of the death are that the Deceased was admitted to the Emergency Department at the Maelor Hospital Wrexham on the 8th of February 2015 following an overdose of co-codamol and whilst awaiting admission to the Medical Admissions Unit she used ECG Leads as a ligature resulting in a hypoxic brain injury. |
| 5 | **CORONER'S CONCERNS**<br><br>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.<br><br>The **MATTERS OF CONCERN** are as follows :-<br><br>1. That there are invariably delays in admissions to hospital as there are insufficient beds available to accommodate all admissions.<br><br>2. That the issue of "bed blocking" is more acute at weekends due to reduced numbers of patients being discharged from hospital. |

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| 6 | **ACTION SHOULD BE TAKEN**<br><br>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**<br><br>You are under a duty to respond to this report within 56 days of the date of this report, namely by 10th March 2017 I, the coroner, may extend the period.<br><br>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**<br><br>I have sent a copy of my report to the Chief Coroner and to the legal representatives of the following Interested Persons – The Family of The Deceased.<br><br>I am also under a duty to send the Chief Coroner a copy of your response.<br><br>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 January 2017** **[SIGNED BY CORONER]** |