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 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 18th of December 2017 I commenced an investigation into the death of Neville Welton. The investigation has not yet concluded and the inquest has not yet been heard.
4	**CIRCUMSTANCES OF THE DEATH** On the evening of the 12th of December 2017 the Deceased attended the Emergency Department at Wrexham Maelor Hospital following a referral from his GP. Due to a combination of factors including (but not exclusively) capacity and patient flow problems, staffing issues and administrative/escalation failures, there was a delay in him being assessed and treated, his condition deteriorated and he passed away in the early hours of the following morning.
5	**CORONER'S CONCERNS** During the course of the investigation my inquiries 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 :- The various factors referred to in paragraph 4 will be further considered at the inquest hearing, however I am concerned firstly by the length of time taken by the Health Board to conclude its Confidential Investigation and to formulate an Action Plan as this was not completed until the 27th of April 2018, some four and a half months after Mr Welton's death. I am further concerned that notwithstanding that an Action Plan had been established with agreed timescales for implementation of actions, these timescales have not been met and matters remain outstanding at the present time. Whilst this investigation and report relates to the death of Mr Welton, I am concerned generally by the length of time which is taken by the Health Board to conclude its Serious Incident Reviews and thereafter to formulate and implement Action Plans.

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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 by12th July 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 17th May 2018 Signature Senior Coroner for North Wales (East and Central)

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