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 the27th of January 2021 I commenced an investigation into the death of Kyle Nicholas James Hurst (DOB 8.7.91 DOD 24.1.21) The investigation concluded at the end of the inquest on the 22nd of October 2021. The conclusion of the inquest was one of suicide with the cause of death being 1(a) Multi Organ Failure [redacted]
4	**CIRCUMSTANCES OF THE DEATH** The circumstances of this death are that the deceased was admitted to Glan Clwyd Hospital on the 24th of January 2021 after taking in excess of [redacted]. Despite receiving treatment he passed away at the hospital later the same day.
5	**<u>CORONER'S CONCERNS</u>** 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. Evidence given at the inquest by the ED Consultant indicated that it has been recognised that the accelerated administration of N-Acetylcysteine may be beneficial in the treatment of a [redacted] but this has not yet been adopted into a Standard Operating Protocol despite this having been proposed in August 2021 2. Following the issue of a regulation 28 report on the 14th of July 2021 in connection with the inquest touching upon the death of Rhian Roberts in similar circumstances, the response from BCUHB indicated by way of a letter dated the 7th of September 2021 that procedures to mitigate risks due to failure to act on diagnostic results would be approved and active by the 1st of October 2021, however at the time of concluding the inquest of Kyle Hurst on the 22nd of October, this had not been accomplished. 3. I am concerned that the Health Board continue to fail to achieve changes in a timely manner, even in circumstances where they have set their own timeframe and that as a result of this lives are being put at risk.

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 21st December 2021 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 Family of the Deceased and to the Chief Coroner. 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 26th October 2021 Signature  Senior Coroner for North Wales (East and Central)