Kate Sutherland
Assistant Coroner for North Wales (East and Central)

	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO:** Betsi Cadwaladr University Health Board
1	**CORONER** I am Kate Sutherland, Assistant 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 21 December 2020 an investigation was commenced into the death of Ben Christopher Harrison following his death on 18 December 2020. A second pre-Inquest hearing took place on 21 March 2023 following an initial Pre-Inquest hearing last year. The investigation remains ongoing at this time.
4	**CIRCUMSTANCES OF THE DEATH** The circumstances of the death are as follows : Ben was aged 37 at the time of his death on 18 December 2020. He had known psychiatric issues. On 15 December 2020 and whilst a voluntary inpatient at the Ablett Psychiatric Unit, Glan Clwyd Hospital he was found in cardiac arrest with a ligature around his neck, [redacted]. He was resuscitated and oxygen cylinder utilised. The cylinder has two valves, both of which have to be opened before the cylinder will function. The valve on the side of the cylinder was not opened and so Ben was ventilated only on room air. Ben was transferred to Intensive Care Unit and died 3 days later.
5	**CORONER'S CONCERNS** During the course of the Pre-Inquest hearing , the evidence revealed matters giving rise to concerns. 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 Health Board undertook an investigation following Ben's death. The investigation contains an Action Plan arising as a result of the learning. It has taken the Health Board a considerable amount of time to update and provide the Action Plan, the most recent version still containing outstanding actions and yet Ben died over 2 years ago. It is particularly concerning that learning and actions arising therefrom are not more quickly addressed. If the learning, actions and changes are taking so long then there is a risk that deaths will continue in the interim. Overall, there is an evident lack of overall strategic direction to investigations and learning.
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 10 May 2023. I, Kate Sutherland, 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 22 March 2023  Signature Assistant Coroner for North Wales (East and Central)