Kate Sutherland
HM Senior Coroner for North West Wales

	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO:** Betsi Cadwaladr University Local Health Board
1	**CORONER** I am Kate Sutherland, HM Senior Coroner for North West Wales
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 June 2022 an investigation was commenced into the death of Eifion Wyn Huws (DOB 25/4/59) who died on 10 June 2022. The investigation concluded at the end of the inquest on 7 June 2023. The conclusion of the inquest was suicide.
4	**CIRCUMSTANCES OF THE DEATH** The circumstances of the death are as follows : Eifion Wyn Huws was aged 63 at the time of his death on 10 June 2022. He had a past medical history of non-Hodgkin's lymphoma having had the diagnosis on 12 January 2022 and poorer mental health as a result. Other than the lymphoma he had no other significant past medical history. The anticipation of awaiting scans and treatment impacted severely upon his mental health but he had significant family support. Eifion was regularly reviewed by a GP and medicated accordingly. He had previous attempts at self-harm by way of medication overdose or self-inflicted injury. He had been under the care of the Community Mental Health Team including Home Treatment Team and primary care since early 2022 up to his death. His acts of self-harm were impulsive but serious. On 10 June 2022 Eifion had left his home address to attend his daughter's home across the road to let the cat out. There was a concern for Eifion when he did not reply to a text message from his wife around 15 mins later who then attended at their daughter's home and on opening the front door found Eifion suspended by a ligature [redacted]. Eifion was confirmed as having passed away at the property on 10 June 2022 at 10.37 by an attending paramedic.

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. – 1. a. During the Inquest evidence was heard that Eifion's GP had made a 'very urgent' referral to the Single Point of Access and Allocation (SPOAA) on 13 May 2022 indicating that on the background of attempts at ending his life, he was extremely concerned that Eifion was experiencing deterioration in his mental state. This document was contained within the hard copy set of notes held by the Psychiatric Liaison Team. When Eifion attended at the Emergency Department the following day, on 14 May 2022, the Emergency department staff were not aware of this 'very urgent' referral as they only had access to the electronic notes and not the hard copy notes. Had they been aware it is likely to have further informed their decision making. It is concerning that the process of ensuring electronic notes to allow for fully informed decisions around treatment and care based on all available records, is not available to staff. It was not clear at Inquest whether the transition from paper-based notes to electronic notes was a Health Board initiative or a nationally followed initiative. Either way, any delay in ensuring all notes are available electronically is potentially harmful to patients. b. During the evidence it was accepted that 'a' above was not a consideration for improvement as part of the Health Board's investigation and so was not an action within the Action Plan upon which it could make improvements or plan to make improvements. It is surprising that the Health Board did not consider this as an issue which required further consideration and improvements in its learning and improvement. 2. An investigation was commenced by the Health Board into Eifion's death which appears to have been concluded in July 2022 but did not appear to be finalised and ready for sharing / disseminating until March 2023. I have previously issued Prevention of Future Death Reports to the Health Board pertaining to the lack of timeliness of their investigations, specifically in relation to investigations from deaths in 2020 and 2021. Whilst I have previously been advised of improvements into investigation processes in respect of more recent deaths the issue of timeliness remains. Eifion died in 2022 and yet the time it took for the investigation to be completed and shared, with actions undertaken has been too long. I am concerned that deaths will occur when the actions arising are not acted upon in a timely manner.

	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 3 August 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 have also sent a copy to Eluned Morgan, Heath Minister. 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 8 June 2023  Signature HM Senior Coroner North West Wales