Kate Robertson
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 (BCUHB)
1	**CORONER** I am Kate Robertson, 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 27 September 2021 an investigation was commenced into the death of Emily Corfield (DOB 30/12/79) who died on 19 September 2011. The investigation concluded at the end of the inquest on 11 July 2023. The conclusion of the inquest was an alcohol related death.
4	**CIRCUMSTANCES OF THE DEATH** The circumstances of the death are as follows :- Emily Corfield was aged 41 at the time of her death. She had a past medical history of vitamin B12 deficiency, anxiety, depression and excess alcohol consumption. She had some support from alcohol liaison services to assist in her overuse of alcohol. On 20 April 2021 she was admitted into hospital with coffee ground vomiting and chronic alcohol misuse. She was discharged on 26 April 2021 with outpatient OGD and was due for review by alcohol liaison as an outpatient. There was no evidence that she had had an inpatient assessment by the alcohol liaison team. On 30 May 2021 she was admitted into hospital again with coffee ground vomiting and alcohol withdrawal. There was no evidence of the alcohol liaison team involvement whilst an inpatient. Emily discharged herself against advice on 4 June 2021 having the capacity to do so. On 19 September 2021 Emily was found deceased in her bed at her home [redacted].
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 – Emily had two inpatient admissions in the year of her death. Whilst the clinician had noted that she was for referral to the alcohol liaison team there was no evidence that Emily had in fact received any input from them either as an inpatient or as an outpatient nor any referrals to external organisations. It is concerning that there appears to have been no evidence that Emily was receiving support from the Alcohol Liaison Team whilst an inpatient on either occasion despite her long history of alcohol misuse and need for support. In the event that clinicians advise referral to alcohol liaison team, either as an inpatient or as an outpatient there ought to be systems and processes to ensure that this occurs.
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 8 September 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 14 July 2023 K Sutherland. Signature

	Assistant Coroner for North Wales (East and Central)