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, [redacted]
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 the 29th of August 2023 I commenced an investigation into the death of Paul Anthony Roberts (DOB 16.4.62 DOD 15.8.23). The investigation concluded at the end of the inquest on the 17th of July 2024. The cause of death was recorded as being due to 1(a) Knife Injury to heart and the conclusion of the inquest was one of misadventure as although this was a self-inflicted injury there was evidence to support the view that it was not by way of an intention to end his life.
4	**CIRCUMSTANCES OF THE DEATH** In February 2023 the deceased took an overdose and inflicted multiple stab wounds to himself. He had a referral to mental health services and an initial assessment by the home treatment team who then passed his care to the local primary mental health support service (LPMHSS). At this time his case was effectively "lost in the system" and he received no further mental health support. On the 14th of August 2023 he attended the emergency department (ED) at Glan Clwyd Hospital due to concerns around a further deterioration in his mental health. Although he was triaged, no referral for a psychiatric assessment was made for a number of hours and by the time that this error was rectified and psychiatric liaison attended the ED, Mr Roberts had left the department. The following day he harmed himself by way of multiple wounds and died as a result of the same.
5	**CORONER'S CONCERNS** During the course of the inquest the evidence revealed the following 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. – An investigation by the Health Board has identified that there were failings in relation to the care afforded to Mr Roberts both following the February mental health referral and at ED on the 14th of August, however the evidence at inquest indicated that the persons with responsibility for these issues had not been spoken to, nor played a part in the investigation process (respectively

	being the team manager of LPMHSS and the nurse in charge of ED). Furthermore an action plan provided by the health board advised that by the end of May 2024 a leaflet would be available and would be given to patients attending ED with mental health issues and would be provided to them at the time of triage to provide advice, support and an indication of likely waiting times before any psychiatric assessment took place. My concerns are therefore as follows : 1. There do not appear to be any consequences for staff members whose actions or omissions result in a failure to adhere to the policies and procedures which the health board impose for the safe care and treatment of patients and in my opinion this lack of accountability perpetuates future risk to patients. 2. The failure to act in a timely manner when learning and actions have been identified (especially when the timetable has been set by the organisation itself) is incomprehensible and as a result there is a failure to mitigate the risk to patients.
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 12th of September 2024 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 18th July 2024 Signature  Senior Coroner for North Wales (East and Central)