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 1 August 2023 an investigation was commenced into the death of Philip Martin Evans (DOB 9/12/1984) who died on 26 July 2023. The investigation concluded at the end of the inquest on 18 July 2024. The conclusion of the inquest was by way of a narrative :- Philip Martin Evans had consumed a large quantity of medication at home and at the time of this consumption the state of his mind was impaired such that it cannot be said that he intended to end his life by this consumption at this time. At hospital, there were missed opportunities to provide treatment which would probably have afforded time to consider and initiate additional treatment options to the extent that death would probably then have not occurred when it did.
4	**CIRCUMSTANCES OF THE DEATH** The circumstances of the death are as follows :- Philip Martin Evans was aged 38 at the time of his death on 26 July 2023. He had taken approximately 200 different tablets at his home address at around 9-9.30am on 26 July 2023. He was conveyed to Ysbyty Glan Clwyd by a police officer who had attended at his home following a concern for his safety. He was observed and went into cardiac arrest at 15:07. He was transferred to the intensive care unit and died a short time later.

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 – The Health Board conducted an investigation into Philip's death to include a review of his previous mental health care and treatment as well as Emergency Department (ED) care and treatment. This did not identify any concerns from an ED perspective (conducted by a Head of Nursing). The report had been reviewed and approved by the Director or Nursing for the Mental Health and Learning Division and the Integrated Health Council Director. A request for a Statement as part of my investigation from an ED perspective prompted a second review of the ED care and treatment which was completed only on 10 July 2024. This was undertaken by an Emergency Department matron, approved by the Divisional Director, reviewed at an Incident Learning Panel and had Executive Approval which was completed on 10 July 2024, 8 days prior to the already listed Inquest. This identified omissions in the care and treatment. At the Inquest an ED Consultant gave evidence to the Investigation Report with this evidence differing in parts to the second investigation report. I am concerned that the quality, effectiveness and timeliness of the Health Board's investigations means that issues or concerns with care and treatment are not being identified either at all or quickly enough in order to put in place additional measures or learning to prevent deaths in similar circumstances. I have issued several Reports pertaining to this very point over a long period and yet the same concerns remain.
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 16 September 2024. I, Kate Robertson, 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. A copy will also be sent to the Health Minister, [redacted]. 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 July 2023  Signature Assistant Coroner for North Wales (East and Central)