

# **Regulation 28: REPORT TO PREVENT FUTURE DEATHS**

NOTE: This form is to be used **after** an inquest.

### **REGULATION 28 REPORT TO PREVENT DEATHS**

# THIS REPORT IS BEING SENT TO:

# 1 Elysium Healthcare

## 1 CORONER

I am Caroline Saunders, Senior Coroner for the coroner area of Gwent.

### 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 01 December 2022 I commenced an investigation into the death of Huw Irwin ERASMUS aged 34. The investigation concluded at the end of the inquest on 05 December 2024. The conclusion of the inquest was that:

Narrative Conclusion

Narrative Conclusion - Huw Irwin Erasmus was at risk of eating vegetation present in the grounds of the Aderyn Unit in Pontypool. Huw died from the toxic effects of consuming a large quantity of Yew leaves in the grounds. Those responsible for his care ought to have known that Yew trees were present, and the leaves were highly toxic and could be fatal if ingested. His death was an accident but it was contributed by a failure of those responsible for his care to identify and manage the risks associated with the ingestion of Yew leaves.

# 4 CIRCUMSTANCES OF THE DEATH

Huw Irwin Erasmus died on 11/11/2022 at Aderyn Unit in Pontypool where he was detained under Section 3 of the Mental Health Act.

Huw died from the toxic effects of consuming a large quantity of Yew leaves. Huw did not consume the leaves with the intention of ending his life.

#### 5 CORONER'S CONCERNS

During the course of the investigation my inquiries revealed matters giving rise to concern. In my opinion there is a risk that future deaths could occur unless action is taken. In the circumstances it is my statutory duty to report to you.

# The MATTERS OF CONCERN are as follows:

(brief summary of matters of concern)

Huw was detained at Aderyn Mental Health Hospital from 8/8/2022 to 11/8/2022 under Section 3 of the Mental Health Act. During that time he was granted unescorted leave within the grounds of the hospital. Huw had a propensity to ingest vegetation and it was a condition of his leave that he refrain from so doing.

The expectation according to the policy and from staff who gave evidence was that Huw would be assessed following a period of leave. It was also anticipated that this assessment would on occasion include a review of whether Huw had ingested vegetation.



There was no documentary evidence in the clinical records that Huw had been so assessed after a period of unescorted leave. There was also confusion amongst staff about the nature of the assessment and the level of documentation required.

Ultimately, the issue was whether in fact these assessments had taken place at all. Although in the circumstances this was not a finding made by the jury, it raises the concern that a failure to understand the requirements of a post-leave assessment and suitably document the findings could result in future deaths.

### 6 ACTION SHOULD BE TAKEN

In my opinion action should be taken to prevent future deaths and I believe you (and/or your organisation) 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 06 February, 2025. 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 Chief Coroner and to the following Interested Persons

### **Family Members Of Huw Erasmus**

I have also sent it to

## **Health Inspectorate Wales**

who may find it useful or of interest.

I am also under a duty to send a copy of your response to the Chief Coroner and all interested persons who in my opinion should receive it.

I may also send a copy of your response to any person who I believe may find it useful or of interest.

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: 12/12/2024

Caroline Saunders Senior Coroner for Gwent