## REGULATION 28: REPORT TO PREVENT FUTURE DEATHS

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| | **REGULATION 28 REPORT TO PREVENT FUTURE DEATHS**<br><br>**THIS REPORT IS BEING SENT TO:**<br><br>The Chief Executive, Hywel Dda University Health Board, Glangwili General Hospital, Dolgwili Road, Carmarthen, Carmarthenshire, SA31 2AF |
| 1 | **CORONER**<br><br>I am Jonathan Mark Layton, Senior Coroner for the coroner area of Carmarthenshire and Pembrokeshire. |
| 2 | **CORONER'S LEGAL POWERS**<br><br>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**<br><br>On 22 April 2016, Emily Katherine Inglis was found deceased in her bedroom on the Bryngofal Ward at Prince Philip Hospital, Llanelli, with a plastic bag over her head. At the time of her death she was detained under the provisions of the Mental Health Act. A post-mortem examination report provided a cause of death as plastic bag asphyxia.<br><br>On 27th April 2016 I commenced an investigation into the death of Emily Katherine Inglis The investigation concluded at the end of the inquest on 15th April 2019. The conclusion reached by the jury was one of misadventure. |
| 4 | **CIRCUMSTANCES OF THE DEATH**<br><br>(1) Emily Katherine Inglis was born on 9 June 1989 and was 26 years of age at the time of her death. She had a history of mental health illness and at the time of her final admission to hospital in December 2015 suffered from a borderline personality disorder.<br>(2) The inquest considered, inter alia, the risk assessments undertaken, the record-keeping and the suitability of an acute psychiatric inpatient unit to treat patients with borderline personality disorder. |
| 5 | **CORONER'S CONCERNS**<br><br>During the course of the inquest the evidence revealed these 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.<br><br>The **MATTERS OF CONCERN** are as follows:<br><br>(1) The inquest identified that there should have been an overarching risk management plan in place to assist medical professionals and staff in treating and caring for Emily.<br>(2) The inquest further identified that there were deficiencies in record-keeping, both in terms of ensuring that risk management strategies remained up-to-date |

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| | and in preserving handover records. |
| 6 | **ACTION SHOULD BE TAKEN**<br><br>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**<br><br>You are under a duty to respond to this report within 56 days of the date of this report, namely by the 25th July 2019. I, the Senior Coroner, may extend the period.<br><br>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**<br><br>I have sent a copy of my report to the Chief Coroner and to the following Interested Person:<br><br>[redacted] c/o Deighton Pierce Glynn, Solicitors, 10th Floor, Unit C, Whitefriars, Lewins Mead, Bristol, BS1 2NT<br><br>The Chief Executive ,Hywel Dda Health Board, Glangwili General Hospital, Dolgwili Road, Carmarthen, Carmarthenshire, SA31 2AF<br><br>I am also under a duty to send the Chief Coroner a copy of your response.<br><br>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 | **30 May 2019** **Signed: J M Layton** |