REGULATION 28: REPORT TO PREVENT FUTURE DEATHS

	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO:** **Chief Executive West Wales General Hospital Glangwili Carmarthen Carmarthenshire SA31 2AF**
1	**CORONER** I am Jonathan Mark Layton, senior coroner for the coroner area of Carmarthenshire and Pembrokeshire.
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 18th February 2014 I commenced an investigation into the death of Mihangel ap Dafydd. The investigation concluded at the end of the inquest on 29 April 2016. The conclusion reached by the jury was a narrative one namely that: On 16th February 2014 Mihangel ap Dafydd hanged himself on Morlais Ward Glangwili Hospital. He was properly assessed under the Mental Health Act upon his admission to hospital. His level of observation was appropriate in the circumstances. The procedure for removing items of property which could be used for the purposes of self-harm was undertaken incorrectly. The hospital unit had not been correctly adapted to prevent windows being used as a ligature point. These failings did contribute to his death.
4	**CIRCUMSTANCES OF THE DEATH** (1) On 14th February 2014 Mr ap Dafydd was exhibiting signs of mental illness and was assessed as being at risk of self-harm. (2) He was detained under the Mental Health Act and placed under 15 minute observations on Morlais Ward Glangwili Hospital. (3) He was checked during the early hours of 16th February and was found hanging from a window having used a strap from his bag.
5	**CORONER'S CONCERNS** During the course of the inquest the evidence revealed this matter 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** is as follows: The windows in service user areas at Morlais Ward are not ligature free and whilst it is intended to make them so following the death of Mr ap Dafydd this work has not yet been undertaken.

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 the 28th June 2016. 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 Person: [redacted] Welsh Government Cathays Park Cardiff CF10 3NQ 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	**3 May 2016** **Signed:**