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, Ysbyty Gwynedd, Penrhosgarnedd, Bangor, Gwynedd LL57 2PW, Wrexham County Borough Council, The Guildhall, Wrexham,
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 the15th of October 2018 I commenced an investigation into the death of Hannah Elizabeth Browning (DOB 18.4.96 DOD 12.10.18) The investigation concluded at the end of the inquest on the 12th of April 2021. The conclusion of the inquest was a narrative in the following terms (and was formulated to include the circumstances by which she came to her death as Article 2 was engaged.) "Hannah Elizabeth Browning was being treated for her mental health issues from mid-December 2017 until her death on the 12th of October 2018. She had a diagnosed condition of Emotionally Unstable Personality Disorder, likely triggered by her being raped at the age of thirteen and exacerbated by chronic pain from a physical problem. During the period of her treatment she was known to have self-harmed and to have had suicidal thoughts. On the 10th of October 2018 she expressed to persons engaged in her care and treatment that it was her intention to end her life that day, yet despite this, inadequate arrangements were made to protect her and insufficient efforts were made to keep her safe. On that same date, in the general location where she had been raped as a child, she placed a ligature around her neck and hanged herself with the result that she sustained a hypoxic brain injury which resulted in her death at the Wrexham Maelor Hospital on the 12th of October 2018"
4	**CIRCUMSTANCES OF THE DEATH** The circumstances of Hannah's death are detailed in the above narrative conclusion.
5	**<u>CORONER'S CONCERNS</u>** 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. – That despite giving an indication of an immediate and fixed plan to harm herself, which she then acted upon, the Mental Health Services made inadequate arrangements to protect her and made no attempt to contact her to either seek to ensure her safety or to advise her of the intention to review her case at an MDT five days later and to reinforce the interim options available to her in crisis.

	Despite hearing evidence at the inquest of the steps taken by BCUHB and WCBC (who act in partnership for the provision of Mental Health Services) to improve the service, I was not provided with any assurances as to measures which had or could be taken to ensure that every possible effort is made to contact a person under their care, who has communicated a credible indication of an immediate risk of harm to themselves.
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 8th of June 2021 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 representatives of 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 13th April 2021 Signature  Senior Coroner for North Wales (East and Central)