Kate Robertson
Senior Coroner for North West Wales

	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, HM Senior Coroner for North West Wales
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 18 May 2021 I commenced an investigation into the death of Lynsey Sarah Smalley (DOB 6/3/79) who died on 16 May 2021. The investigation concluded at the end of the inquest on 7 September 2023. A narrative conclusion was recorded with the cause of death as:- 1a Septic Shock 1b Airway burns with inhalation injury On the 8th April 2021, Lynsey Sarah Smalley deliberately set fire to her bed at her home address during an acute psychotic episode. The smoke from the fire caused inhalation injury which led to her admission to the Intensive Care Unit at Ysbyty Gwynedd, Bangor. Lynsey Sarah Smalley remained in the intensive care unit for several weeks with poor respiratory progress. She did not recover from her injuries and died at Ysbyty Gwynedd, Bangor on 16th May 2021. Given her psychotic episode it cannot be said that she intended to end her life by causing the fire.
4	**CIRCUMSTANCES OF THE DEATH** The circumstances of the death are as follows :- The deceased was aged 42 at the time of her death on 16 May 2021. She had a past medical history of mixed schitzotypal and emotionally unstable personality disorder with traits of Asperger's syndrome. She had mobility difficulties and required a bariatric bed due to concerns regarding skin integrity. She lived at home with her brother who cared for her. Lynsey Smalley was known to the Community Mental Health Team (CMHT) since 2005 and had a Care Coordinator who was a Community Psychiatric nurse. She was also open to a Psychiatrist and an Occupational therapist. On 6 April

	2021 the CMHT were contacted by Lynsey's brother who was concerned that Lynsey was acting strangely. A second call was made by her brother with concerns that Lynsey had relapsed and was displaying signs of paranoia, auditory and olfactory hallucinations, irritability, poor sleep and isolating herself in a particular room. A further call was made with reported concerns that Lynsey was lighting candles, had not used her prescribed oxygen and had not been eating, drinking, or sleeping for the past 4 days. It was indicated that there were only certain professionals Lynsey would agree to see but that she had agreed to see the care coordinator the following day. The GP prescribed medication and Lynsey's brother was advised to contact Police if the situation became difficult. There was a total of 4 calls made by Lynsey's brother to the out of hours crisis team. In addition, Lynsey's brother contacted the emergency services for assistance. Police officers attended and a CID16 was completed and sent to the CMHT the following morning. By 9.10am on that same morning the CMHT reviewed the out of hours report. The care coordinator arrived at L's home at 10.30am. Lynsey was reluctant to engage, and her brother reported concerns including that Lynsey had not slept for several nights, was not eating or drinking. He reported the incident overnight where Police had attended. The Care coordinator returned to the office and discussed with a psychiatrist, who agreed to visit that same day and the Advanced MH practitioner to assess and consider admission. After approximately 10 minutes of the care coordinator leaving Lynsey ignited a fire in the property. Emergency services were contacted. Lynsey was taken to Ysbyty Gwynedd, Bangor where she remained until she passed away on 16th May 2021.
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 – a. The Health Board provided 3 investigation reports into the death, two of which contained conflicting evidence. One responded to Lynsey's brother's complaint. It is clear that there was no strategic plan or collaboration in governance processes. Furthermore, there were a number of proposed actions which took nearly two years to identify and complete. The time it took to identify and complete actions, together with governance processes are matters which I have raised previously with the Health Board in previous Prevention of future Death Reports. If there are such disjointed patient safety and governance processes learning will not be effective and deaths will continue to occur or will occur into the future. b. A number of individuals and organisations are involved in the care of those under mental health teams or at times have contact with patients e.g. CMHT, Home Treatment Teams, Psychiatrists, Occupational therapists, Care

	Coordinators, out of hours crisis service (local authority based in Gwynedd), Police, Ambulance Service etc. As medical records remain paper based not all individuals or organisations who need to understand a patient's circumstances/care/treatment are privy to all aspects of care/treatment. In addition, where a CMHT patient is receiving in-patient mental heath treatment the paper notes are transferred to the hospital setting. There is a risk that notes will become lost in full / in part. Having medical records electronically will not only allow full access to all notes to those who require which will inform future care/treatment but will also ensure effective continuity of care, without the risk of missing or lost notes. I have previously issued a Prevention of Future Deaths Report on this point, a copy of which was also sent to [redacted], Health Minister.
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 3 November 2023. 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. I have also sent a copy of this Report to [redacted], Health Minister, for her information. 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 8 September 2023  Signature Kate Robertson HM Senior Coroner for North West Wales