GRAEME HUGHES

HIS MAJESTY'S SENIOR CORONER

SOUTH WALES CENTRAL CORONER AREA

CORONER'S OFFICE
THE OLD COURTHOUSE
COURTHOUSE STREET
PONTYPRIDD
CF37 1JW

[redacted]

ANNEX A

REGULATION 28: REPORT TO PREVENT FUTURE DEATHS (1)

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

	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO:** · The Rt Hon Lucy Frazer KC MP, Secretary of State for Digital, Culture, Media and Sport · Ofcom · Eluned Morgan, Welsh Health Minister
1	**CORONER** I am Graeme D Hughes Senior Coroner, for the Coroner Area of South Wales 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 10 September 2020 I commenced an investigation into the death of Bronwen Grace MORGAN (BM) . The investigation concluded at the end of the inquest 20/10/2023. The conclusion of the inquest was Suicide. **1a** [redacted] **Toxicity** **1b** **1c** **II**

4	**CIRCUMSTANCES OF THE DEATH** Bronwen Morgan had a diagnosis of Emotionally Unstable Personality Disorder. This manifested itself in fluctuating symptoms including acute periods of distress and anxiety leading to acts of deliberate self-harm. She was under the care and treatment of local mental health services. She was engaging in dialectical behaviour therapy the indicated treatment for Emotionally Unstable Personality Disorder. On 27.8.20 she has travelled to a hotel possessing a toxic substance that she had purchased [redacted]. She was located in the hotel by the emergency services and conveyed to the University Hospital of Wales, Heath. Despite resuscitation attempts she did not regain consciousness and died from the toxic consequences of the substance. Material located on her mobile phone and at the scene demonstrated that she likely intended the consequences of her deliberate actions to be her own death.
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. The evidence revealed that as from at least February 2020, BM had registered with, & was engaging in discussion forums [redacted] This website was mentioned in an earlier PFD Report dated 3.12.19 (copy annexed). The engagement that BM had with the website encompassed her discussing & seeking advice from fellow users in respect of, methods of self-harm/suicide including the purchasing & use of the substance [redacted]. This was the substance used by BM which led to her death. The concern here is that this site & potentially similar self-harm & suicide "facilitating, or promoting" sites are accessible/available to those, such as BM who are vulnerable, due to their diagnosed, or otherwise mental illness & provided with an outlet/forum to source & acquire information that potentially equips them with the knowledge & means to either complete suicide, or place them in grave/greater danger of doing so. I believe that consideration ought to be given to the impact such access/availability has upon those vulnerable individuals researching/contemplating acts of self-harm & whether, & what action(s) may be taken to remove/limit/mitigate/educate such access/availability.
6	**ACTION SHOULD BE TAKEN** In my opinion action should be taken to prevent future deaths and I believe you and your organisation(s) 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 20th December 2023, or if I, the Coroner, extends 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 family, the Health Board and Public Health Wales who may find it useful or of interest. 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	25 October 2023 **SIGNED:**  Senior Coroner for South Wales Central Coroner Area

[redacted] [redacted]