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 Chief Executive of the Cwm Taf Morgannwg University Health Board and the Welsh Government.**
1	**CORONER** I am David Regan, Assistant 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** A Coronial investigation was commenced on 19th July 2022 into the death of Isobel Lilian Stapleton. The Investigation concluded at the end of the inquest which I conducted on 19th June 2024. The conclusion was that Ms Stapleton died from suicide. The medical cause of death was 1 (a) Incisional Injury to Right Femoral Artery and Vein.
4	**CIRCUMSTANCES OF THE DEATH** These were recorded as: - Isobel Stapleton, aged 32, suffered depression. She was admitted to the Royal Glamorgan hospital as a voluntary inpatient on 18th June 2022 for assessment and was reviewed by a consultant psychiatrist. She was discharged on 24th June 2022, returned to reside with her father and received treatment from the home treatment team. On Saturday 9th July 2022 Ms Stapleton was at home and appeared to give no cause for concern until her father heard her call from upstairs. He found her on the floor of her bedroom with significant bleeding [redacted] He summoned help and comforted her as she lost consciousness. Paramedics were deployed at 14.49 and attended at 14.54 but her life could not be saved. It is likely that her injuries were self inflicted. Ms Stapleton expressed a clear intention to end her life in a hand written note found at the scene. The Inquest focused upon the following: - 1. The assessment and management of the risk posed by Ms Stapleton to herself. 2. The information available to medical professionals and information sharing between professionals and agencies. 3. The availability of psychological assessment and treatment resources to the inpatient team at the Royal Glamorgan hospital and the home treatment team covering Merthyr Tydfil. 4. The involvement of Ms Stapleton's family in discharge planning.
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. For your information the **MATTERS OF CONCERN** are as follows: - (1) Mental health practitioners are not easily able to access all of a patient's relevant

[redacted] [redacted]

	clinical records pending the introduction of a "Once for Wales" solution, for which there is currently no timetable for implementation. (2) Mental health practitioners may not be aware of the existence of all such records, some of which may be in paper. (3) Mental health practitioners in Wales currently have no way easily to access NHS England clinical records. (4) The inpatient hospital team at the Royal Glamorgan Hospital did and does not have access to a clinical psychologist to provide direct assessment and treatment of a patient. (5) The Home treatment team covering Merthyr Tydfil does not have access to a clinical psychologist to provide direct assessment and treatment of a patient. The waiting list for any necessary psychotherapy is months in length.
6	**ACTION SHOULD BE TAKEN** In my opinion action should be taken to prevent future deaths and I believe you and your organisation 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. 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.

[redacted] [redacted]

8	**COPIES and PUBLICATION** I have sent a copy of my report to the following who may find it useful or of interest: Ms Stapleton's family, the Medical Director of the Cwm Taf Morgannwg University Health Board. 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 June 2024 **SIGNED:** D R Regan David Regan Assistant Coroner for South Wales Central Coroner Area

[redacted] [redacted]