REGULATION 28: REPORT TO PREVENT FUTURE DEATHS

	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO:** **THIS REPORT IS BEING SENT TO:** **CHIEF EXECUTIVE** **SWANSEA BAY UNIVERSITY HEALTH BOARD** **1 TALBOT GATEWAY** **BAGLAN ENERGY PARK** **BAGLAN** **PORT TALBOT** **SA12 7BR**
1	**CORONER** I am Kirsten Heaven, Assistant Coroner, for the coroner area of SWANSEA & NEATH PORT TALBOT
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 20 February 2025 I heard the inquest into the death of Amy Marie Padley. The medical cause of death was: 1a Hanging The conclusion of the inquest was a narrative conclusion as follows: Amy Marie Padley had a diagnosis of emotionally unstable personality disorder ('EUPD') and historically had a diagnosis of depression and is recorded as having problems with an eating disorder and body dysmorphia. From the age of 16 and then for many years Amy had was prescribed various anti-depressant and other medications. Amy also suffered from a longstanding and harmful addiction to alcohol which escalated closer in time to her death in a context of family divorce and family breakdown. Amy had some limited early involvement with community mental health services when she was young and then had not engaged. In the two years before her death Amy had overdosed twice and had experienced some fleeting suicidal ideation and had been admitted to hospital. Roughly four months before her death Amy had undergone an emergency alcohol detoxification in a

	hospital setting whilst on the waiting list for alcohol services from a third sector agency. Amy had engaged with a number of third sector agencies in the two years before her death to help with her alcohol addiction, but her engagement had been sporadic, and she often disengaged. Amy had also been offered and turned down appointments to see mental health professionals. Amy was engaged with one third sector agency at the time of her death. Three weeks before her death Amy overdosed on a dangerous level of medication but then felt remorse and expressed plans for the future. Amy had also expressed wanting psychiatric input to assist with overcoming her alcohol addiction. Amy was discharged from hospital after being assessed by Liaison Psychiatry but was not referred to the community mental health team as the view was that Amy first needed to address her alcohol addiction. There were several opportunities that were missed by Swansea University Bay Health Board ('SUBHB') staff to refer Amy to the community mental health team for assessment in the primary care setting including when Amy overdosed on 18 June 2022 shortly before her death. I find that that this was because too much emphasis was placed by SUBHB staff on Amy needing to seek help to first addresses her alcohol addiction with insufficient consideration given to Amy's underlying mental health diagnosis and the role that may have been playing in her mental health deterioration. There was also insufficient attention given to the difficulties Amy faced in engaging with third sector organisations for her alcohol addiction and her inability to consistently seek help for herself and whether this was because of her mental health diagnosis. Amy was known to engage in impulsive and dangerous acts of self-harm and to experience suicidal thoughts when intoxicated and that Amy was suffering from long-standing alcohol addiction. I consider that this posed a risk to her life and that this risk (i.e. life-threatening self-harm when intoxicated and when having suicidal thoughts) was not given sufficient consideration when she was discharged by Liaison Psychiatry three weeks before her death. There were several missed opportunities for mental health services to try and engage Amy before her death so that they could assess her and undertake a medication review. I am unable to say whether these missed opportunities contributed to Amy's death as I do not know whether Amy would have engaged with any appointment that she was offered and whether an assessment would have been arranged and/or had any meaningful impact before Amy took her own life. On the 8 July 2022 Amy was found by her daughter, hanging [redacted]. Attending paramedics and Police confirmed the death at 06.50hrs. I am satisfied that Amy took her own life and intended to do so.
4	**CIRCUMSTANCES OF THE DEATH** The deceased Amy Marie Padley. Amy Marie Padley suffered from alcohol addiction and depression and was diagnosed with an EUPD. On 18 June 2022 Amy overdosed and had an inpatient admission. Amy was then discharged by Liaison Psychiatry with no mental health follow up. Amy was found deceased at her home having taken her own life by suspension and was declared deceased on 8 July 2022 at 06.50.

5	**CORONER'S CONCERNS** During the inquest the evidence revealed matters giving rise to a 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 make a report under paragraph 7, Schedule 5 of the Coroners and Justice Act 2009 and Regulations 28 and 29 of the Coroners (Investigations) Regulations 2013 The **MATTERS OF CONCERN** is as follows: I am concerned about the evidence I heard in this inquest that when an individual is suffering from alcohol or drug addiction alongside a mental health diagnosis, which in this case was EUPD and depression, that the focus of SUBHB is normally to advise that individual to address their addiction before they can access mental health services. I heard that addiction services do not fall within the remit of SUBHB and are provided by third-sector agencies. I heard that individuals who have a mental health diagnosis may self -medicate to manage symptoms of a mental health deterioration and that increased use of alcohol/drugs can increase the risk of self-harm to such individuals which may prove fatal. I am concerned that there is no guidance to staff within SBUHB on how to manage individuals with addiction and a mental health diagnosis and how SUBHB staff should liaise with and work alongside third-sector agencies in respect of an individual suffering from addiction. I am also concerned that there appears to be a reluctance within SBUHB to offer mental health support alongside suggesting that an individual access addiction services. I am concerned that this may mean that individuals in mental health crisis and suffering from addiction may not be getting the mental health assessment and support that they require alongside seeking to overcome their addiction and as such there is continuing risk to life.
6	ACTION SHOULD BE TAKEN In my opinion action should be taken to prevent future deaths and I believe 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 21st April 2025. 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 Persons, the family of Amy Marie Padley.

	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	24 February 2025