Kate Robertson
Assistant Coroner for North Wales (East and Central)

	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, Assistant 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 2 July 2024 an investigation was commenced into the death of Leanne Marie Carroll (DOB 6/9/1996) who died on 29 June 2024. The investigation concluded at the end of the inquest on 17 March 2025. The conclusion of the inquest was a narrative conclusion that 'Death was due to misadventure where Leanne had not been referred to the Perinatal Mental Health Service either during her pregnancy or at any point up to her death'.
4	**CIRCUMSTANCES OF THE DEATH** The circumstances of the death are as follows :- Leanne Marie Carroll was aged 27 at the time of her death on 29 June 2024. She had given birth to her first child approximately 8 months prior to her death. Leanne suffered from anxiety and, although not diagnosed, Obsessive Compulsive Disorder (OCD). She sought assistance from her GP and she was referred in March 2024 to the Community Mental Health Team. She was referred to an OCD support group. It was noted that her OCD had deteriorated since giving birth. Leanne died from the excessive consumption of prescribed and non-prescribed medications. At no time had any health professional referred Leanne to the Perinatal Mental Health Service who could have supported her.
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 – 1. The Perinatal Mental Health Service was established across the Health Board around 5 years ago. It was accepted in evidence that there is insufficient awareness of the Service by health professionals including midwives, health visitors and GP's. Whilst attempts have been made to raise awareness and encourage direct referrals to the Service (rather than via the Single Point of Access) this remains inadequate. If health professionals are unaware of the Service then mothers-to-be and mothers who require assistance will not be fully supported. 2. There are only 2 temporary perinatal health visitors across the 3 Health Board areas and not one in the Eastern area of the Health Board. By not having permanent perinatal health visitors acros all three Health Board areas then those who need to access support will suffer 3. The Single Point of Access meetings which occur on a daily basis by way of triaging referrals do not provide written records of the discussions had and decisions made. This means that there is no written justification for decisions made or written actions and therefore these discussions and decisions do not form part of any health record for the patient which would be relevant to the overall management of the patient. 4. I am concerned that deaths will occur into the future as awareness of the Service is not at all adequate to health professionals, the Service is not adequately staffed and records of meetings and decisions made in the Single Point of Access are not documented.
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 14 May 2025. 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 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 19 March 2025  Signature Assistant Coroner for North Wales (East and Central)