

GRAEME HUGHES
HIS MAJESTY'S
SENIOR CORONER
SOUTH WALES CENTRAL
CORONER AREA



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

Telephone: 01443 281100
Facsimile: 01443 485862
Email: Coroneradmin@rctcbc.gov.uk

ANNEX A

REGULATION 28: REPORT TO PREVENT FUTURE DEATHS (1)

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

	<p>REGULATION 28 REPORT TO PREVENT FUTURE DEATHS</p> <p>THIS REPORT IS BEING SENT TO:</p> <p>██████████ – Chief Executive Cwm Taf Health Board</p>
1	<p>CORONER</p> <p>I am Graeme D Hughes Senior Coroner, Area of South Wales Central.</p>
2	<p>CORONER'S LEGAL POWERS</p> <p>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.</p>
3	<p>INVESTIGATION and INQUEST</p> <p>On 4 May 2021 I commenced an investigation into the death of Paige Jeanette ALLEN . The investigation concluded at the end of the inquest 25/05/2023. The conclusion of the inquest was Misadventure.</p> <p>The medical Cause of Death determined to be:-</p> <p>1a Multiple Blunt Force Injuries</p> <p>1b</p> <p>1c</p> <p>II</p>

Coroner's Office, The Old Courthouse, Courthouse Street, Pontypridd, CF37 1JW

Phone/Ffôn (01443) 281100 Fax/Ffacs (01443) 485862

CIRCUMSTANCES OF THE DEATH

4

Paige Allen had a diagnosis of Emotionally Unstable Personality Disorder. Symptoms of this disorder included impulsive risk-taking behaviour at times of high anxiety. On the late evening of 20.4.21 into the early hours of 21.4.21 she has travelled to Southerndown Cliffs, [REDACTED]. She has contacted the emergency services who have attended and attempted a rescue. It is more likely than not, that during the same she has lost her footing, her ability to remain in position and fallen to her death. Her death was confirmed at 3.07am on 21.4.21. At the time that she left the cliff edge it was not found that she deliberately did so.

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.

Whilst I did not find that the matter of concern outlined below was directly causative of, nor contributory to, Miss Allen's death, my concern broadly is that those patients who contact mental health services in Cwm Taf Morgannwg University Health Board (CTMUHB), especially at the time of crisis may be assessed without the assessing practitioner having immediate & comprehensive access to relevant and proximate medical records, notes & plans (such as WARRN assessments, & Care & Treatment Plans).

5


More particularly, the evidence indicated that should a patient present to mental health services in the Bridgend locality, but have their secondary mental health care managed in either the Merthyr/Cynon locality or the Rhondda/Taff/Ely locality or vice versa, the assessing practitioner will not immediately i.e. at the time of assessment, have access to that patient's FACE records.

My concern is that this has the potential to deprive the assessing practitioner of pertinent and proximate material which may increase the risk of an incomplete or insufficient assessment.

That being potentially significant in informing the assessing practitioner of his/her action/planning for that individual in crisis.

Whilst I received evidence that CTMUHB has pledged to adopt a system, which it is believed will ameliorate the current situation, I am concerned that until such time as the same is available and immediately accessible across the three localities, the risk identified persists.

Interim measures may wish to be considered to mitigate the risk identified.

6	<p>ACTION SHOULD BE TAKEN</p> <p>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.</p>
7	<p>YOUR RESPONSE</p> <p>You are under a duty to respond to this report within 56 days of the date of this report, namely by 21st July 2023 only I, the Coroner, may extend the period.</p> <p>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.</p>
	<p>COPIES and PUBLICATION</p> <p>I have sent a copy of my report to family who may find it useful or of interest.</p> <p>Also to Health inspectorate Wales and the Health Minister</p> <p>I am also under a duty to send the Chief Coroner a copy of your response.</p> <p>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.</p>
9	<p>26 May 2023</p> <p>SIGNED:</p> <p></p> <p>for South Wales Central Coroner Area</p>