	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO:** 1. NHS ENGLAND; and 2. NORTH STAFFORDSHIRE COMBINED HEALTHCARE TRUST.
1	**CORONER** I am Emma Serrano Area Coroner for **Stoke-on-Trent & North Staffordshire Coroner's Court**
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. http://www.legislation.gov.uk/ukpga/2009/25/schedule/5/paragraph/7 http://www.legislation.gov.uk/uksi/2013/1629/part/7/made
3	**INVESTIGATION and INQUEST** On 29/07/2019 I commenced an investigation into the death of Rebecca Claire Pykett, aged 39. The investigation concluded at the end of the inquest on 8th July 2021. The conclusion of the inquest was Rebecca Claire Pykett passed away at her home address of [redacted] Congleton Road, Talke, Stoke-on-Trent on the 25 February 2019. She passed away after she intentionally hung herself using a tie, that she had fashioned into a ligature and attached to the bedpost, in the bedroom, of her home address. The Medical Cause of death was recorded as follows: 1a) Asphyxiation 1b) Hanging
4	**CIRCUMSTANCES OF THE DEATH** Rebecca Pykett had a history of mental health difficulties which included a diagnosis of PTSD. These issues became more prominent in October of 2018. This led to three informal inpatients stays in the Harolands Hospital: 1. 10.11.18 – 12.11.18 2. 12.12.18 – 16.12 18 3. 15.01.19 – 18.01.19 She also had periods where she was under the care of the Trust's Home Treatment: 1. 12.11.18 – 12.12.18 2. 15.01.19 – 21.01.19 3. 03.02.19 – 06.02.19 She was found deceased, having ligatures with a tie in the bedroom of her home address on the 25 February 2019. She was due to attend a medication review with Dr [redacted] (a Consultant Psychiatrist) that day, but did not attend.
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) During the course of the inquest evidence was hear in regard to the fact that each patient who is under the care of the CMHT should be allocated a Care Co-Ordinator. This Care Co-Ordinator will be responsible for co-ordinating the care that each CMHT patient will receive.

(2) The allocation of the Care Co-Ordinator was of concern as there was no system to ensure that a Care Co-Ordinator was actually being allocated into this role. What was taking place was that a clinician was being chosen, in Rebecca Pyketts case, her Consultant Psychiatrist who was no, in fact carrying out the role, and tasks expected as a care co-ordinator.

(3) An example would be that the allocated Care Co-Ordinator should be allocated within 5 days, see their patient within 5 days, and complete a care plan. This did not happen in Rebecca Pyketts' case.

(4) It appears that there was routine allocation of the allocated Consultant Psychiatrists as care co-ordinator. The reason behind this routine allocation was that Lorenzo (the patient record keeping system employed by the north Staffordshire Combined Healthcare NHS Foundation Trust), required this box to be filled in. Therefore the allocation of the care Co-Ordinator was being dealt with as a "box ticking" exercise, to satisfy the record keeping system.

(5) Once allocated, in this way, it ws clear from the evidence that was produced at inquest that no such role was carried out by the Care Co-Ordinator.

6	**ACTION SHOULD BE TAKEN** In my opinion action should be taken to prevent future deaths and I believe you NHS England and North Staffordshire Combined Healthcare NHS Foundation Trust and/or 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 XXX. 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 1) The Family of Rebecca Pykett; 2) North Staffordshire Combined healthcare NHS Foundation Trust I am also under a duty to send the Chief Coroner a copy of your response and all interested persons who in my opinion should receive it. I may also send a copy of your response to any other person who I believe may find it useful or of interest. 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.
9	17/07/2021 Signature  Emma Serrano Area Coroner **Stoke-on-Trent & North Staffordshire Coroner's Court**