REGULATION 28: REPORT TO PREVENT FUTURE DEATHS

	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO:** **1. Secretary of State for Health and Social Care, 39 Victoria Street, London, SW1H 0EU** **2. Greater Manchester Health and Social Care Partnership, Floor 4, 3 Piccadilly Place, Manchester, M1 3BN**
1	**CORONER** I am Adrian Farrow, Assistant coroner, for the Coroner area of Manchester South.
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 8th September 2020 an investigation was commenced into the death of Rebecca Jayne Flint (also known as Rebekah Jayne Flint), aged 46 years. The investigation concluded at the end of the inquest on 17th March 2022. The conclusion of the Inquest was that she committed suicide by asphyxiation.
4	**CIRCUMSTANCES OF THE DEATH** At the time of her death, Rebecca Flint was under the care of the Trafford Community Mental Health Team, having been discharged into their service on 2nd May 2020 from a period as an in-patient at the Moorside Unit under s2 of the Mental Health Act 1983. A Care Coordinator from the Mental Health team was assigned to Ms Flint prior to her discharge from hospital and the Care Coordinator remained in place until Ms Flint's death on 7th September 2020. There was an escalating pattern of self-harm which was known to the Community Mental Health Team which can be summarized as follows: 04/07/2020 – [redacted] 08/07/2020 – [redacted] 09/07/2020 – [redacted] 16/07/2020 – [redacted] 27/08/2020 [redacted] 31/08/2020 [redacted] Ms Flint told her Care Coordinator on 4th September 2020 that she had been carrying [redacted]. Ms Flint was found at her home on 7th September 2020, [redacted]

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 could occur unless action is taken. In the circumstances it is my statutory duty to report to you. The **MATTERS OF CONCERN** are as follows. – From the evidence I heard, the Care Coordinator's role is to assess the patient's care needs and to plan and review those needs across the broad spectrum of physical and mental health and social needs within the multi-disciplinary team within the Mental Health Trust. The Care Coordinator is the individual who has the closest contact with the patient and, as the title suggests, is the liaison link for every other professional and agency. From the evidence, it is clear that an enormous burden of responsibility and reliance is placed on the individual Care Coordinator as they are expected to be the conduit of information to other professionals and to continuously review and assess all areas of the patient's needs and to call in others as required. I concluded that the only person who had the ability to have a comprehensive view of Ms Flint's mental health was the Care Coordinator and the quality of the information provided to others within the multi-disciplinary team and other agencies was entirely dependent on the ability, availability, resources, experience, training and skills of the Care Coordinator. (1) From the evidence, it appeared that the precise job description and requirements of Care coordinators differs between local Trusts so that there is no consistency as to the way in which individual Care coordinators are expected to fulfil their role. (2) It also emerged that the resources available to the Community Mental Health Teams are limited so that in the absence of a Care Coordinator during periods of annual leave or sickness, there was no other Care Coordinator who could fulfil the role.
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 by **11th September 2022**. 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. I have also sent it to [redacted] on behalf of Miss Flint's family and to the Chief Executive of the Greater Manchester NHS Foundation Mental Health Trust who may find it useful or of interest. I am also under a duty to send a copy of your response to the Chief Coroner 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	**Adrian Farrow** **HM Assistant Coroner**  **17.07.2022**