REGULATION 28: REPORT TO PREVENT FUTURE DEATHS

	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS THIS REPORT IS BEING SENT TO: Greater Manchester Police and Greater Manchester Health & Social Care Partnership.
1	CORONER I am Alison Mutch, Senior Coroner, for the Coroner Area of Greater 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
3	INVESTIGATION and INQUEST On 31st March 2020 I commenced an investigation into the death of Jade Rayner. The investigation concluded on the 6th April 2021 and the conclusion was one of accidental death. The medical cause of death was 1a Toxic effects of fluoxetine.
4	CIRCUMSTANCES OF THE DEATH Jade Nicole Rayner was significantly impacted by domestic abuse and used alcohol to help her deal with the underlying mental trauma from it. She developed seizures and was prescribed medication for them and antidepressants for her mental health. As a result of the mental trauma, alcohol use and seizures, she was a vulnerable adult with complex mental and physical health needs. She had fluctuating capacity. Her vulnerability, fluctuating capacity and the complexity of her needs required effective communication between agencies and an effective multi agency strategy to address then and reduce the risk she presented. Such a plan was not in place. On 30th March 2020 Jade Nicole Rayner was found unresponsive at her home address, [redacted] Post-mortem examination included toxicology. She was found to have in her system a fatal level of her prescribed antidepressants and alcohol at a level that would cause significant intoxication.

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 inquest was told that her capacity fluctuated and she was vulnerable. Her social worker reported to Greater Manchester Police and to NWAS that it was believed she had been the victim of a sexual offence involving an employee of NWAS who had initially been to her address in a professional capacity. The inquest heard that NWAS dealt with this robustly through their internal disciplinary process. The inquest was told that GMP did not record it as a crime. The officer giving evidence to the inquest initially gave evidence that GMP had 72 hours to decide if GMP should record a sexual allegation as a crime. It was then indicated that it should have been recorded as a crime. The inquest was told it was not investigated and was written off following a strategy meeting. Jade Rayner was not as a consequence offered by GMP the support set out within the Victims Code. 2. Her case was complex, and the evidence was that there was not a clear multi agency strategy to support her particularly to share information and understand the relationship between earlier Domestic abuse and the subsequent use of alcohol. 3. The evidence was that the existing available alcohol misuse support programmes whilst useful could not meet the needs of a complex case such as this where underlying trauma was a key driver.
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 18th June 2021. 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 namely [redacted] (family of the deceased), Pennine Care Legal Department, North West Ambulance Service Legal Department, Inspectorate of constabulary, [redacted] who represented Stockport Metropolitan Borough Council and the organisation Change Grow Live, who may find it useful or of interest. 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: 30th April 2021 Signature: Alison Mutch HM Senior Coroner, Manchester South