REGULATION 28: REPORT TO PREVENT FUTURE DEATHS

	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO: The Chief Constable, Greater Manchester Police.**
1	**CORONER** I am John Pollard, senior coroner, for the coroner area of South Manchester
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 9th February 2015 I commenced an investigation into the death of **Michael Lee Thorley** dob 3rd September 1968. The investigation concluded on the 25th June 2015 and the conclusion was one of an Open Conclusion. The medical cause of death was 1a Combined opiate/opioid toxicity
4	**CIRCUMSTANCES OF THE DEATH** **The deceased was at his home address which is a first floor flat reached by a staircase from the ground floor. There was a telephone call made to the North West Ambulance Service, by a female voice, saying that 'she' was Michael Thorley and that he was unable to breathe. The caller then collapsed and nothing further was heard and an ambulance was despatched to the scene. The ambulance call taker notified the police and police officers attended. When they got to the scene they found that the outer door was locked and there was a metal grille type door over that front door, and that too was locked. Consideration was given to breaking down the door, but instead, despite two of the officers being trained in the use of wham-rams, one officer then went off to try to find the next of kin to see whether a key could be obtained to gain entry. By the time that officer returned to the flat with the next of kin (who did not have a key) some 23 minutes had passed since the police first arrived at the scene. The pathologist gave evidence to me, that had the deceased been treated with a dose of naloxone (the 'antidote' to morphine) immediately upon their arrival, there "is a chance that his life might have been saved". The officers then broke down the door, which took about 30 seconds and found the deceased in the property.**
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. **There was an inordinate and inexcusable delay in gaining entry to the premises where it was known that the caller to the ambulance service had apparently collapsed mid-call.**

	2. **There was no clearly thought-out and applied policy as to whether it was better to risk breaking down a door unnecessarily or whether to risk the life of someone who may be collapsed inside.** 3. **When the officers searched the premises they failed to find approximately five empty methadone bottles which were in a kitchen cupboard.** 4. **The telephone which was used to make the call was found (after the ambulance service re-called it), well away from the body. No explanation for this was forthcoming. This issue was not even considered as needing examination by the attending officers.** 5. **None of the investigating officers considered that a third party may have made the phone call and then tidied up the flat and left, locking the door from the outside. When the officers gained entry there was no drug paraphernalia nor were there any opened prescribed medication packets. There was a large quantity of prescribed medication, none of which had been opened. There was no explanation as to why or how this situation may have arisen: This despite the fact that it was known that the deceased's friend had been present the previous night/early morning, and that she could have had a key. It was assumed that the door had been locked from the inside although there was no evidence to support that contention.** 6. **The Detective Inspector did not attend the scene on the day as it was deemed not a Special Procedure Death and not one where he needed to attend. The representative of the Professional Standards Branch concurred with the view expressed by the Coroner that a D.I. should turn out to this type of death.**
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 **1st September 2015**. 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] **(mother of the deceased)**. 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	**7th July 2015** [redacted] **John Pollard, HM Senior Coroner**