REGULATION 28: REPORT TO PREVENT FUTURE DEATHS

	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO: The County Fire Officer and Chief Executive, Greater Manchester Fire and Rescue Service, 146, Bolton road, Swinton, Manchester M27 8 US**
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 21st October 2015 I commenced an investigation into the death of **Lee Richard Gaunt** dob 26th October 1973. The investigation concluded on the 11th February 2016 and the conclusion was one of **Suicide**. The medical cause of death was **1a Hanging**.
4	**CIRCUMSTANCES OF THE DEATH** **On the 17th October 2015 he went to work the night shift at Stalybridge Fire Station. He had recently been suffering a loss of confidence at work following the death of a colleague in a fire in Manchester where he was one of the commanders. He was found hanging from a tree at the Fire Station.**
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 appeared to be rather less than effective support from Occupational Health and it took a long time for the deceased to be able to see the doctor.** **2. Whilst it was known by the Fire and Rescue Service that he was suffering as a result of the death of his colleague, nonetheless he was required to take on the extra duties of Crew manager and Watch Manager.** **3. In the aftermath of the death of his colleague, and whilst being forced to take on the extra Watch Manager job, he was also having to cope with the extra (and as he regarded it, strenuous) task of leading the fire-fighters as First-Responders to assist North West Ambulance Service in attending cardiac arrest calls.** **4. It became apparent in the course of the evidence, that the deceased and his wife felt there was a general failure by the GMFRS to care for and**

	support staff in stressful situations.
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 **29th April 2016**. 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] (wife 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	**4.3.16** **John Pollard, HM Senior Coroner**