REGULATION 28: REPORT TO PREVENT FUTURE DEATHS

	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS THIS REPORT IS BEING SENT TO: To go to National Police Chiefs Council Secretary of State for the Home Office Chief Executive of the College of Policing Victims Commissioner for England
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 23rd September 2019 I commenced an investigation into the death of Donna Constantine. The investigation concluded on the 30th September 2021 and the conclusion was one of open. The medical cause of death was unascertained.
4	CIRCUMSTANCES OF THE DEATH On 21st September 2019 Donna Ann Constantine was found at her home address [redacted] after neighbours raised concerns. She was severely decomposed. Post mortem examination could not establish a cause of death due to decomposition. Donna Ann Constantine was a vulnerable adult known to multiple agencies including Mental Health Services and Greater Manchester Police. She had repeatedly expressed suicidal ideation in the past. She had taken the tenancy at [redacted] from 12th August 2019. She was supported by the Housing Resettlement Worker from her temporary accommodation. She was referred to the Housing Support Service for support post her move. She sent a text message to her Housing Resettlement Worker and a Greater Manchester Police Officer whose work mobile number she had been provided with to indicate she was very unwell on 18th August 2019. She sent no text messages after 20th August 2019. Attempts to follow up dropping off her belongings were not made after 22nd August 2019. Unsuccessful attempts to contact her by the Housing Support Team were

	not escalated. The last known activity from her phone was on 22nd August 2019. No concerns for welfare were raised in the period from 22nd August until she was found on 21st September 2019.
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. – The inquest heard evidence that as part of the way in which GMP have sought to embed the Victims Code and engage with victims Police Officers are actively encouraged to provide victims/vulnerable members of the community with their work mobile telephone numbers. Those given the number are encouraged to use those numbers to raise concerns with the Police. In this case that is what Donna Constantine did. However the phones are not monitored when officers are off duty or on annual leave. This the inquest heard created an ongoing risk that vulnerable members of the community would contact officers in a way e.g. text/voicemail that would not necessarily allow their contact to be dealt with immediately. The inquest was told that this promotion of contact via mobile telephone numbers was not restricted to GMP and was in fact part of a national policing approach. It had been recognised that there were risks involved in encouraging contact in this way but no solution had been identified to reduce the risk. In contrast to contact via 999 and 101 there was no clear escalation policy for officers to follow if they received calls from members of the community and no clear policy regarding the creation of an audit trail of actions taken and no way of recording the calls verbatim unlike calls to the call handling team.
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 14/12/2021. 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 the family of the deceased, 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	19/10/2021 Alison Mutch HM Senior Coroner