ANNEX A

REGULATION 28: REPORT TO PREVENT FUTURE DEATHS (1)

*NOTE: This form is to be used **after** an inquest.*

	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO:** **1. [redacted] Chief Executive Officer, Mitie Care & Custody Limited** **2. [redacted], Chief Constable, Greater Manchester Police**
1	**CORONER** I am Jason Wells, 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 28 January 2020 an investigation was commenced into the death of ANTHONY JAMES FITZPATRICK (dob 16 May 1987). The investigation concluded at the end of the inquest on 8 November 2021. The conclusion of the inquest was [redacted]. The medical cause of death was: [redacted]
4	**CIRCUMSTANCES OF THE DEATH** (1) Anthony Fitzpatrick (AF) had a long history of mental health problems and presented at local A&E departments, with [redacted], on 3 occasions in the 12 months prior to his death. On the latter two occasions, in November 2019 and January 2020 he was later taken into custody, at Swinton and Cheadle Custody Suites respectively. (2) Following assessment by the Custody Sergeant AF was seen by a Health Care Professional (HCP, employed by Mitie), who recorded the risk of [redacted] in the electronic custody record, using a drop down menu.

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. – (1) During the course of the evidence, it became apparent that the HCPs were not using objective and/or consistent criteria to assess the risk of [redacted], meaning that (a) the grade of risk assigned to AF was inconsistent and/ or inaccurate and (b) no one else knew what was meant by the grade of risk recorded in the electronic custody record. (2) Further, none of the HPCs who gave evidence used the criteria described in the online training materials. (3) Despite being aware of this problem, there was no plan in place to address it.
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 1 February 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 and to the following Interested Persons: the Family, Greater Manchester Mental Health NHS Foundation Trust, Cheshire & North West Boroughs NHS Foundation Trust and Greater Manchester Care & Rehabilitation Company. I have also sent it to the Quality Care Commission, 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	**Date: 7 December 2021**  **Jason Wells**