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. Chief Constable [redacted], Greater Manchester Police** **2. Director General [redacted], Independent Office for Police Conduct**
1	**CORONER** I am Rachel Raheela Syed, H M Assistant Coroner, for the coroner area of Manchester West
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 26/04/2021 I commenced an investigation into the death of Hannah Grace Beardshaw, aged 25. The investigation concluded at the end of the inquest on 04/04/2022. The conclusion of the inquest was suicide.
4	**CIRCUMSTANCES OF THE DEATH** The deceased was formally pronounced dead at her home address of [redacted], [redacted] Wigan on the 20th April 2021. The deceased had a complicated medical history and had struggled with her mental health for many years, having previously attempted to take her own life. In the period leading up to her death, she struggled to cope with life and researched methods of taking her own life on the 19th April 2021. On the 20th April 2021 at 11.47am, the deceased contacted a friend requesting that her cat was looked after. She was crying and left a detailed note of intent saying goodbye to her loved ones. Welfare concerns were raised to Greater Manchester Police (GMP) at 12.30pm and the incident generated a 20 minute allocation and 1 hour vehicle response. An ambulance was requested to the incident at 12.45pm and arrived at scene at 2.10pm. At 2.26pm, Greater Manchester Police were contacted by ambulance control requesting police assistance to gain access to the premises. At 3.14pm, 3.59pm and 4.14pm, ambulance control continued to chase Greater Manchester Police for an estimated time of arrival. Greater Manchester Police officers arrived on scene at 4.47pm and a method of entry officer arrived on scene at 5.17pm to gain access to the property. The deceased was discovered hanging having used a [redacted]. A paramedic was deployed and diagnosed death at 5.36pm on the same day.
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. –

	The IOPC highlighted a number of learning recommendations on how GMP handled the incident which to date have not been implemented: • A delay in escalating the incident, resulting in almost a 4 hour delay to respond to the incident. • A failure to make method of entry kits more readily available to those trained in their use. • Improvement in document management
6	**ACTION SHOULD BE TAKEN** In my opinion urgent action should be taken to prevent future deaths and I believe you and/or your organisation 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 8th June 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: [redacted] Mother of deceased. [redacted] Father of deceased I am also under a duty to send a copy of your response to the Chief Coroner and all interested persons who in my opinion should receive it. I may also send a copy of your response to any other person who I believe may find it useful or of interest. 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.
9	**Date** **13th April 2022** **Signed** **Rachel Raheela Syed, H M Assistant Coroner for Manchester West**