**ANNEX A**

**REGULATION 28: REPORT TO PREVENT FUTURE DEATHS (1)**

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

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| | **REGULATION 28 REPORT TO PREVENT FUTURE DEATHS**<br><br>**THIS REPORT IS BEING SENT TO:**<br><br>**1.** The Chief Constable,<br>Greater Manchester Police Headquarters<br>Central Park<br>1 Northampton Road<br>Manchester<br>M40 5BP |
| 1 | **CORONER**<br><br>I am Professor Dr Alan Peter Walsh, HM Area Coroner for the Coroner Area of Manchester West |
| 2 | **CORONER'S LEGAL POWERS**<br><br>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**<br><br>On the 2nd February 2021 I commenced an investigation into the death of Angeline Marie Phillips, 35 years, born on the 20th December 1985. The investigation concluded at the end of the inquest on the 5th December 2022.<br><br>The medical cause of death of Angeline Marie Phillips was:<br><br>1a) [redacted] Toxicity<br><br>The conclusion of the investigation at the Inquest was Misadventure. |
| 4 | **CIRCUMSTANCES OF THE DEATH**<br><br>1) Angeline Marie Phillips (hereinafter referred to as "the Deceased") died on the 30th January 2021 at her home address at 2 Wilbraham Road, Walkden, Manchester. |

2) The Deceased was found having died at her home address at 03.48 hours on the 30th January 2021, having had no contact with family or friends after 19.44 hours on the 28th January 2021.

3) On the 29th of January 2021at 18.09 hours a friend of the Deceased contacted Greater Manchester Police by telephone and reported a concern for the welfare of the Deceased. The friend confirmed that the Deceased had been in and out of Hospital (both Salford Royal Hospital and the Royal Bolton Hospital) in the previous week following on from numerous suicide attempts. The home address of the Deceased was given to the Police as 2 Wilbraham Road, Walkden, Manchester.

4) The Call Handler graded the priority response to the reported incident under the Greater Manchester Response Policy, which was last amended to Version 1.4 on the 24th June 2019. The response was graded as Grade 2 Priority Response, which requires the radio operator to allocate the incident within 20 minutes and attendance within 1 hour from the creation of the Incident Log.

5) A police officer did not attend 2 Wilbraham Road, Walkden, Manchester and at 20.28 hours on the 29th of January 2021 a Sargent, who was the Command and Control Supervisor, made a decision that the incident was a medical matter and the North West Ambulance Service (hereinafter referred to as "NWAS") needed to deal with the incident. The incident was reported to NWAS at 20.32 hours.

6) NWAS attended the Deceased's home address at 23.06 hours and confirmed that there was no answer at the address or from any contact numbers and the Ambulance crew had left the address to attend another incident.

7) At 00.03 hours on the 30th January 2021 the Command and Control Supervisor noted the Incident Log "For Allocation" but a Police officer still did not attend the address at 2 Wilbraham Road, Walkden, Manchester until entry to the address was forced at 03.48 hours by police officers and the deceased was found having died in the property.

**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 Inquest evidence was heard that: -

    a) The Greater Manchester Police Incident Response Policy governed the grading of an Incident in relation to priority and the response time to an Incident.

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| | b) In relation to the grading of the Incident relating to the Deceased, which was reported at 18.09 hours on the 29th of January 2021, the Incident was graded correctly as a Grade 2 Priority Response with a response time of 1 hour but a police officer only attended more than 8 hours after the report of the Incident with the Incident having been referred to NWAS without a police officer attending.<br><br>c) The Greater Manchester Police Incident Response Policy makes no reference of an option to refer the Incident to a 3rd Party, such as NWAS, but there is no specific reference in the Policy that the attendance must be by a police officer and that the responsibility to attend must not be passed to a 3rd party or any other agency.<br><br>d) I am concerned that unless the Greater Manchester Police Incident Response Policy is reviewed police officers will not attend Incidents within the timescales referred to in the Policy and there will be an opportunity to pass the responsibility to 3rd party agencies, which may lead to a risk that future deaths could occur unless action is taken.<br><br>2) I request that you conduct a review of the following concerns<br><br>a) A review of the Greater Manchester Police Incident Response Policy to consider specific reference in the Policy that the attendance must be by a police officer and that the responsibility to attend must not be passed to a 3rd party or another agency.<br><br>b) When the review has taken place implement to consider the implementation of a training programme for all police officers and civilian staff involved in the operating procedures referred to in the Greater Manchester Police Incident Response Policy |
| 6 | **ACTION SHOULD BE TAKEN**<br><br>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**<br><br>You are under a duty to respond to this report within 56 days of the date of this report, namely by **15th February 2023** I, the coroner, may extend the period.<br><br>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. |

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| 8 | **COPIES and PUBLICATION**<br><br>I have sent a copy of my report to the Chief Coroner and to the following Interested Persons<br><br>1. [redacted] Sister of the Deceased<br>2. Independent Office of Police Conduct<br>3. Greater Manchester Mental Health Trust – DAC Beachcroft Solicitors<br><br>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.<br><br>I may also send a copy of your response to any other person who I believe may find it useful or of interest.<br><br>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.<br><br>You may make representations to me, the coroner, at the time of your response, about the release or the publication of your response. |
| 9 | **Dated 21st December 2022** **Signed**<br><br>**Professor Dr Alan Peter Walsh,**<br>**HM Area Corner,**<br>**Manchester West** |