REGULATION 28: REPORT TO PREVENT FUTURE DEATHS

	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS THIS REPORT IS BEING SENT TO: Chief Constable of Greater Manchester Police
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 19th April 2022 I commenced an investigation into the death of Rebecca Alice Fisher. The investigation concluded on the 18th April 2023 and the conclusion was one of **Suicide.** The medical cause of death was **1a) Drug Toxicity**
4	CIRCUMSTANCES OF THE DEATH On 15th April 2022, Rebecca Alice fisher was found deceased by her family in a secluded area of Reddish Vale. Post-mortem examination included toxicology. She had a fatal dose of drugs in her system including pregabalin. [redacted] Rebecca had been reported by the Norbury Ward to Greater Manchester Police (GMP) as a high-risk missing person on the 11th April at about 6pm after she failed to return from 30 minutes of unescorted leave. Rebecca had a complex mental health history [redacted] She had been admitted to the Norbury ward as a crisis patient. [redacted]. She had been allowed to leave for 30 minutes of unescorted leave. It was recognised that this presented a risk. Her failure to return was correctly assessed by hospital staff as creating an escalated risk and a high-risk situation. Greater Manchester Police failed to correctly assess her as a high-risk missing person. As a consequence, this meant that mobile telephone enquiries were not immediately undertaken, and the investigation did not have specialised input in the hours immediately following her being reported missing. It is probable that

	if these enquiries had taken place Greater Manchester Police would have known she was in the area of her home address and Reddish Vale. It is possible that Rebecca would have been found before she died had she been treated as a high-risk missing person.
5	<u>CORONER'S CONCERNS</u> 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 GMP have guidance to support officers in assessing risk and guiding actions when there is a missing person report. The evidence was that despite the existence of the policy/document the risk was not recognised as being high risk and the appropriate actions were not taken immediately. The evidence indicated that a number of factors were key in this failure to accurately assess the risk. This included: 1. Poor understanding by GMP staff of the fact that a patient detained on a voluntary basis in a mental health ward could still be high risk if they failed to return; 2. Lack of understanding by GMP staff that the use by mental health units of short periods away from the unit to support a patient's recovery did not mean a patient could not be high risk if they did not return; 3. Lack of understanding by officers of how to apply the golden hour guidance and what was the expectation in terms of timeliness of undertaking the steps within the guidance coupled with a lack of understanding by some officers of the way/cost to GMP in accessing mobile phone data such as cell site; and 4. Poor quality documentation and information sharing between officers and supervision in relation to information from the family and the mental health unit. The inquest was told that GMP had rolled out an Aide Memoire system to try to embed greater consistency and understanding of the policy across GMP. The Aide Memoires were recognised as being an effective tool. However, there was no evidence available to assist in understanding if the Aide Memoires were being used effectively across the force and how GMP were measuring the implementation of them. Evidence was given to the inquest that GMP have introduced further training on missing persons. However, the effectiveness of that training was unclear given witnesses who had been on the training who gave evidence remained of the view that Rebecca was not a high-risk missing person despite all of the evidence available at the inquest.

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 10th July 2023. 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 1) [redacted] on behalf of the Family; 2) Pennine Care, 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	**Alison Mutch** **HM Senior Coroner**  **15.05.2023**