REGULATION 28: REPORT TO PREVENT FUTURE DEATHS

	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO:** 1. Greater Manchester Police 2. The College of Policing
1	**CORONER** I am Anna Morris, Assistant 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 the 25th October 2022, I commenced an investigation into the death of Samuel Curless (Sam). Sam died on the 24th October 2022 at the Manchester Royal Infirmary. He was 29 years old. The investigation into his death concluded on the 2nd February 2024 when I completed the inquest into his death. **The medical cause of death was found to be 1a) Hypoxic Ischaemic Encephalopathy caused by 1b) hanging.** I recorded a conclusion of suicide.
4	CIRCUMSTANCES OF THE DEATH Sam had a long history of anxiety and depression. He had reported feeling suicidal in the past. He was the sole carer for his young son and his son was a protective factor for him. On the 23rd September 2022, the deceased was arrested at home in relation to an allegation of a serious criminal offence. He was taken to the police station where he was interviewed under caution. He was released on bail the same day with conditions not to have any contact with anyone under the age of 18.

On Friday 21st October, Sam was informed that all of his bail conditions were removed, but that he remained under investigation. He was provided with police documentation that confirmed this. Sam contacted the children's social worker and informed her of the change to his bail and asked if he could now see his son unsupervised. The social worker told him that she would need to verify the bail position with the police before their plan could change. Sam agreed to continue with the supervised contact on Monday, but he would have found it difficult to hear and understand.

At 14:05 on Saturday 22nd October, Sam made a call to GMP 101 service from his mobile phone. This call was connected to a GMP Call Handler at 14:12 and a police log was commenced. From the audio recording of the call, Sam could be heard telling the Call Handler that he thought he had found a dead body. He gave the location [redacted]. He said it was the first plot near some stainless-steel containers near the car park. The conversation between the deceased and the call handler lasted approximately 40 seconds, after which Sam did not respond to further attempts at engagement. The call handler kept the line open for just over 5 minutes.

As the deceased's call to GMP was a 101 call (and not a 999 call), the Call Handler was not able to obtain the precise location using his mobile phone and data services. She obtained a street name to add to the location after talking to her supervisor. The Call Handler did not know that the deceased had any intent to take his own life, but she did conclude that there was a risk that the dead body he was reporting might not be dead. At 14:29 she graded the THRIVE risk as High and Graded the GMP Response as 1. She coded the call as G15 which includes a concern for welfare or risk of suicide. Radio Operators dispatched GMP officers at 14:33.

The Call Handler failed to call an ambulance at 14:29. It was a GMP minimum standard expectation that she should have done so at the point that she had a location to dispatch to and was part of her training in response to reports of a dead body. [redacted] gave evidence to the inquest that this was an admitted failing by GMP, but I found that it did not make any material contribution to the death.

Two Officers attended [redacted] at 14:38 within the Grade 1 response time. They located the Sam in a shed [redacted] at 14:42. They found him suspended from a ligature [redacted]

The first officer on the scene assumed that she was looking at a dead body. She did not check for a pulse until around 14:46. A total of three officers were in attendance by this point. A further check at 14:48 revealed that he was still warm and only at that point was he cut down. After further checks for a pulse, CPR was commenced by the officers at

	14:50. The three initial attending officers failed to administer any basic life support to Sam for approximately 8 minutes after discovering him suspended. The officers failed to perform any immediate initial checks of Sam's vital signs when they discovered him. The officers failed to remove the ligature and therefore an airway obstruction at the earliest opportunity. It was GMP and College of Policing Policy that officers attending a suspected sudden death should not assume death, should make preservation of life their priority and not delay in administering basic life support until an ambulance arrives. In their evidence to the inquest, these failings were admitted by the officers but I found that did not make any material contribution to the death. The attending officers all assumed that an ambulance had been called by GMP comms. In fact, one was only contacted at 14:48. NWAS went mobile at 14:57 and attended the scene at 15:01 and commenced advanced life support. Following paramedic intervention, spontaneous circulation returned at 15:24. Sam was then taken to Manchester Royal Infirmary, where despite appropriate resuscitation and life preserving treatments he died on the 24th October 2022.
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. – 1. That in respect of GMP Call Handler's being required to call an ambulance to attend the scene, even where it is reported that someone is "dead" there has been no institutional learning following this incident. I asked [redacted] if there had been any learning, reflection or training since this incident. He said that there hadn't on this issue. 2. That the training delivered to the first two attending officers did not adequately prepare them for responding to a scene where someone is found hanging in a way which is consistent with their priority to preserve life of a hanging casualty. 3. I heard evidence from Detective Superintendent [redacted] that both attending officers were part of a cohort of at least 650 officers within GMP (and a larger cohort nationally) who received their

	initial police training entirely online. I am concerned that both officers' training on Sudden Death (and the training of others) was delivered as one of over 15 online modules on a given day and that at the time of the inquest, they had not received any classroom based or on the job training. I am concerned that they are not the only officers within GMP who have received this level/method of training input and therefore there is a risk that other officers on duty have inadequate training on this issue. 4. There was evidence given to me by Detective Superintendent [redacted] that there is an unknown number of GMP officers who are not meeting the expectation of receiving First Aid refresher training within 12 months, which since May 2022 has included training on how to resuscitate a hanging casualty. I am therefore concerned that there remains a cohort of officers who have not had the post May 2022 training that includes how to provide Basic Life Support to this kind of casualty until the arrival of an ambulance.
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 15th April 2024. 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) Sam's Family; 2) Independent Office of Police Conduct (IOPC); 3) Tameside Metropolitan Borough Council**, 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	**Anna Morris** **HM Assistant Coroner**  **19th February 2024**