## Regulation 28: REPORT TO PREVENT FUTURE DEATHS

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

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| | **REGULATION 28 REPORT TO PREVENT DEATHS**<br><br>**THIS REPORT IS BEING SENT TO:**<br>**1 Greater Manchester Police**<br>**2 Chief Coroner**<br>**3** [redacted]<br>**4 College of Policing**<br>**5 IOPC -Independent Office for Police Conduct** |
| **1** | **CORONER**<br><br>I am Zak GOLOMBECK, HM Area Coroner for the coroner area of Manchester City |
| **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** | **INQUEST**<br><br>The Inquest was opened on 12th March 2024. The final hearing has not yet taken place. Following disclosure of evidence from Greater Manchester Police ("GMP") and the Independent Office for Police Conduct ("IOPC"), there is concern that future deaths will occur, and I am of the opinion that action should be taken to reduce the risk of death. |
| **4** | **CIRCUMSTANCES OF THE DEATH**<br><br>Mr Ashley Crews died on 20th February 2024 from injuries sustained from a fall from height. On 20th February 2024, GMP officers attended Mr Crews' address (a 9th floor flat) to execute an arrest warrant. The attending officers did not apply handcuffs. Mr Crews proceeded to walk to his bedroom in the flat, and whilst some officers followed him, Mr Crews was able to open a window and jump out. GMP have confirmed that they do not have a local policy dealing with the use and application of handcuffs when executing an arrest warrant. The IOPC have confirmed there is no national policy. |
| **5** | **CORONER'S CONCERNS**<br><br>During the course of the investigation my inquiries 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.<br><br>The **MATTERS OF CONCERN** are as follows:<br>(brief summary of matters of concern)<br><br>1. There is no local policy for the use of handcuffs when executing an arrest warrant. |
| **6** | **ACTION SHOULD BE TAKEN**<br><br>In my opinion 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** |

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| | You are under a duty to respond to this report within 56 days of the date of this report, namely by June 18, 2024. 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. |
| **8** | **COPIES and PUBLICATION**<br><br>I have sent a copy of my report to the Chief Coroner and to Interested Persons. I have also sent it to organisations who may find it useful or of interest.<br><br>I am also under a duty to send the Chief Coroner a copy of your response.<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. 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** | **Dated: 23/04/2024**<br><br>**Zak GOLOMBECK**<br>**HM Area Coroner for**<br>**Manchester City** |