	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS This report is being sent to: Chief Constable of Avon and Somerset Chief Constable of Surrey College of Policing
1	CORONER I am Robert Sowersby, Assistant Coroner for Avon
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 28 June 2023 my office commenced an investigation into the death of Amy Anne Levy. The investigation concluded at the end of a 5-day inquest on 6 June 2025. The conclusion of the jury who heard the inquest was – '*Amy took a deliberate overdose of prescription drugs on 18th June 2023. It is not possible to know her true intent.*' Police were notified at the time of her overdose but Amy's whereabouts were unknown: much of the evidence in the inquest centred on their attempts to find her address so that emergency services could be sent to help her. This was an article 2 inquest, and in recording how Amy died the jury identified '*a catalogue of missed opportunities to obtain Amy's correct address*' by various bodies including Surrey Police and Avon and Somerset Constabulary. The jury also concluded that if not for those missed opportunities Amy would probably have survived.

4	CIRCUMSTANCES OF DEATH At the time of her death Amy was a 22-year-old student at the University of the West of England (UWE), living at a term-time address in Bristol. While she was in Bristol (on 18 June 2023) she called a friend, took an overdose of prescription drugs, and then steadily deteriorated while remaining on the phone – initially becoming unresponsive and later appearing to stop breathing. Surrey Police were informed of the situation via a 999 call.

	In the ensuing period of over 2 hours before Amy was found Surrey Police and Avon and Somerset Constabulary both tried to obtain her correct address. As part of that effort calls were made by police (i) to Amy's family home in Surrey, and (ii) to her mother's mobile phone. Each call came through with 'no caller ID' and went unanswered. Both police forces knew that Amy had taken an overdose at an unknown address and that her condition was deteriorating. Both forces had graded Amy's case as requiring an 'immediate' response (the most urgent category). Despite that factual background, none of the officers or call handlers who phoned Amy's parents left a voicemail message. Having missed the call/s (from an unknown source or sources) Amy's parents did not know that there was an emergency, or that the police wanted to speak with them, and had no way of calling back whoever had called them. It is probable that Amy's location could have been obtained earlier than it was if the police had left a suitably worded voicemail for one or more of her parents. Amy died in hospital on 22 June 2023. The medical cause of death was determined to be: 1a) Hypoxic brain injury 1b) Quetiapine and zopiclone overdose 2) Depression

5	CORONER'S CONCERNS During the course of the inquest the evidence revealed matters giving rise to concern. As I have outlined above, this was an '*immediate'* priority search to obtain the address of a young woman whose life was believed to be at risk. It is hard to understand the decision (made by more than one police caller) *not* to leave any voicemail/message. We heard evidence from two police Inspectors (one from Avon and Somerset Constabulary and one from Surrey Police) that although there is guidance in Avon *not* to leave voicemails when the incident in question concerns domestic abuse, there is no general guidance about when to leave a voicemail message in other cases (*ie*, it is neither encouraged not discouraged by any policy or standard operating procedure). I was subsequently provided with an updated '*Deployment of Resources Procedure*' from Surrey Police, which indicates that '*call takers and dispatchers must consider whether it is appropriate to leave a voicemail, unless there is a compelling operational reason not to do so*'. It is not clear from the title of the document or the wording of the guidance whether this is intended to affect police
	officers, or only the actions of those in Surrey's contact centre and force control room. The MATTERS OF CONCERN are as follows – With limited or no guidance, training or policy on when police and/or police support staff liaising with the public should leave a voicemail (particularly in circumstances where they are trying to obtain important information in a timepressured situation), I am concerned that there is a risk that future deaths will occur unless action is taken, and in the circumstances it is my statutory duty to report to you.
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 5 August 2025. 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: Amy Levy's family. 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, 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	10 June 2025 Signature:  Robert Sowersby Assistant Coroner for Avon