REGULATION 28: REPORT TO PREVENT FUTURE DEATHS

	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO:** **Greater Manchester Integrated Care**
1	**CORONER** I am, coroner, for the coroner area of South Manchester
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 20th December 2024 I commenced an investigation into the death of Andrew James CONNOLLY .The investigation concluded on the 30th April 2025 and the conclusion was one of suicide. **The medical cause of death was multiple injuries.**
4	**CIRCUMSTANCES OF THE DEATH** On 26th November 2024 Andrew James Connolly was struck by a train having entered the track at [redacted] Railway Station and died there from his injuries.
5	**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 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 whilst initial appointments with his GP were face to face they became telephone appointments even when he indicated that his mental health was not improving. In addition there was no attempt to gain input from his family into the reality of the situation in relation to his mental health. The evidence given by his family at the inquest was that they could have provided valuable information into the

	clinical assessment but did not feel they had the opportunity to provide this information. The consequence of these two factors was that his risk was not recognised. On the evidence before the inquest there is no guidance for the use of telephone appointments in preference to face to face for GPs across GM and no mechanism for family input in these situations.
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 **5th 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 namely : the wife of Mr Conolly on behalf of the family, 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**  **10/06/2025**