Regulation 28: REPORT TO PREVENT FUTURE DEATHS

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

	REGULATION 28 REPORT TO PREVENT DEATHS **THIS REPORT IS BEING SENT TO:** **1 Chief Constable** [redacted] Greater Manchester Police Divisional Headquarters Building Northampton Road Manchester M40 5BQ 2 **Chief Constable** [redacted] College Of Policing Leamington Road Ryton-on-Dunsmore Coventry CV8 3EN
1	**CORONER** I am Mr Timothy William Brennand, HM Senior Coroner for the coroner area of Manchester West.
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 31 March 2025 I commenced an investigation into the death of Elaine TARBUCK aged 69. The Investigation concluded at the end of the Inquest on 25 June 2025. The medical cause of death was: 1a) Exsanguination 1b) Scalp Laceration 2) Ischaemic Heart Disease I returned a narrative conclusion that Elaine Tarbuck died as the consequence of injuries sustained in an accidental fall and the exacerbating effects of pre-existing naturally occurring disease on a background of sub-optimal emergency response.
4	**CIRCUMSTANCES OF THE DEATH** The deceased had a medical history that included Multiple Myeloma with reducing mobility, a history of falls (previous pelvic fracture in November 2024) and low mood, depression and anxiety following the recent death of her husband. Such was the nature extent of concern for welfare, her next-of-kin (who resided a long distance from the deceased) would telephone the deceased several times in the day and had also arranged for family friends to visit daily. She was last spoken to during the evening of the 28th of March 2025. At about 9.40am on the morning of 29th of March 2025, a friend of the deceased attended at

	her residence at [redacted], Westhoughton on a pre-arranged welfare visit. Upon obtaining no response from the deceased, he went to the nearest police station to report his concerns. Little Hulton Police Station was unmanned and closed, but public signage giving advice resulted in a call to the police '101' non-emergency contact line. The concerned friend was instructed that the matter was a welfare and not a policing matter. At 11.52am having confirmed from family and neighbours that the deceased had not been seen and was still not responding to telephone calls to her, the emergency services were contacted via a '999' call. Call handlers determined that an ambulance should attend. Emergency paramedics arrived on scene at 12.18pm but could not gain access to the deceased's property. The Fire Service was therefore requested to attend. Following a forced entry via rear patio doors at 12.50pm the deceased was discovered in a collapsed, unresponsive condition at the foot of the stairs laying in a pool of dried blood from an obvious head injury. She was verified as dead and beyond any attempted resuscitation. The evidence established that after setting the house alarms and heading up the stairs for bed during the preceding evening, the deceased had missed her footing or lost her balance, falling backwards from about three stairs up, landing in a way that caused her to lose immediate consciousness and having also sustained a laceration to her head, thereafter was to exsanguinate without re-gaining consciousness. By reason of the time at which death could be established, it was determined that accepted suboptimal elements in the assessment, quality of questions asked of people contacting the police and emergency services and the resulting information gathering fell below the standard expected and applied as part of the 'Right Care, Right Person' response policy, this did not have any bearing upon the outcome.
5	**CORONER'S CONCERNS** 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. The **MATTERS OF CONCERN** are as follows: During the Inquest, evidence was heard that: 1. Family members who lived far from the deceased became concerned for the welfare of the deceased and were of the view that she had suffered a medical episode, collapse or adverse event that explained her failure to respond to telephone calls and knocks on the door from friends. 2. The full background of the deceased, her history of falls, her recent bereavement and high risk to have suffered an adverse medical episode, or deliberate or unintended physical harm raised the expectation on the part of the family, that having called the emergency services, entry would be forced to the deceased's residence as they were of the view that there was a real and immediate risk of death or serious harm having occurred. 3. In fact, calls to the non-emergency 101 and 999 emergency lines evaluated that this was a non-critical emergency and a presumed medical event. This created a significant delay before it was appreciated that entry would need to be forced and the Fire and Rescue Service were requested to attend. 4. There was lack of understanding as to whether the forced entry would be lawful, a matter for the police, or a matter for Fire and Rescue Services in circumstances that the next-of-kin, if asked, would have agreed readily to there being forced entry at the outset and well before their arrival.

	5. There was accepted sub-optimal information gathering and evaluation of the category of this emergency with an example of poor training resulting in inappropriate language being used by a call handler. 6. The emergency response had come about because of a new 'Right Care, Right Person' policy applied by emergency services that, in fact, delivered as a first responder, the wrong person delivering the wrong care to the deceased's residence. 7. Prior to the implementation of 'Right Care, Right Person' this 'concern for welfare' emergency would have been dealt with by the attendance of the police on the scene as first responders who would have been likely to have achieved entry as a result of the concern for welfare.
6	**ACTION SHOULD BE TAKEN** 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** You are under a duty to respond to this report within 56 days of the date of this report, namely by August 29, 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: [redacted], **Daughter of Elaine Tarbuck** I have also sent it to: **Greater Manchester Fire And Rescue Service** **North West Ambulance Service** who may find it useful or of interest. I am also under a duty to send a copy of your response to the Chief Coroner and all interested persons who in my opinion should receive it. I may also send a copy of your response to any person who I believe may find it useful or of interest. 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: 7th July 2025** **Mr Timothy W Brennand** **HM Senior Coroner for** **Manchester West**