

**KATE GREEN**  
**DEPUTY MAYOR**  
**OF GREATER**  
**MANCHESTER**

Joanne Kearsley

Senior Coroner for the Coroner area of Manchester North

Cc: [REDACTED], College of Policing  
[REDACTED]

30 October 2025

Dear Ms Kearsley

**RE: Regulation 28 Death of Katie Janette Overd (ref: 25030828)**

Thank you for sending me the Regulation 28 letter into the death of Katie Janette Overd.

I will of course review the learning from this case and ensure that this is considered via the Right Care: Right Person (RC:RP) Strategic Oversight Board that I chair.

Your report states that *'if the family had known about the Right Care: Right Person process they would have phoned the locksmith sooner'*. However, Right Care: Right Person is not about *whether* an emergency service will attend an incident, but rather *which* emergency service has the best skills to respond to the call, irrespective of which service received it (the right care for the right person). RC:RP is essentially an internal cross-service reorganisation process whereby pathways are agreed between agencies on which service is best placed to respond to types of incidents following RC:RP principles.

GMP's (and my) view is that a member of the public might not be sure which would be the most appropriate emergency service to call, and so our processes are focussed on ensuring that the caller is routed to the most appropriate service to respond, no matter where a call is received. We would rather a member of public takes decisive action and calls "the emergency services" who can then, through training and experience, identify the most appropriate service to meet their needs (as per RC:RP), rather than delay contact whilst they ponder which service is the right one to respond to the specific circumstances of their scenario – which itself may generate a delay. As you note, we have not therefore focussed on external communication to suggest which service people should call initially, as they should be directed to the right service via the call handler irrespective of which service they call.

Having said that, I recognise in this case that had they had knowledge and understanding of the RC:RP process, that would have likely led to the family calling NWAS initially, which was the advice of the GMP call handler gave when the call was received. In this instance, I believe the delay caused by calling GMP and then calling NWAS was circa 7 minutes. I know that GMP have explored with NWAS

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on whether calls could be transferred directly between the two organisations but unfortunately it has not been operationally practical to do so.

NWAS of course have their own triage system, which triages calls on receipt and identifies the appropriate ambulance response category. You suggest that had the caller understood RC:RP, they would have called a locksmith rather than the emergency services, but RC:RP would not have affected that triage process. Unfortunately, there will always be the concern that a service could have responded quicker and whether any delays may have negatively impacted upon outcome, but I'm afraid I can't comment on triage and response processes in NWAS.

All that said, I am keen to consider the learning from Ms Overd's death and I will discuss the issue of call transfer and external communications again with GMP, NWAS and our wider health and local authority partners through the RC:RP Strategic Oversight Board.

Thank you for raising the case with me.

Yours sincerely



**Deputy Mayor of Greater Manchester**

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