NHS
Greater Manchester
Integrated Care

[redacted]

Date: 26 January 2026

Private & Confidential
Alison Mutch
Senior Coroner Manchester South
Coroner's Court
1 Mount Tabor Street
Stockport
SK1 3AG

[redacted]

Dear Alison

Re: Regulation 28 Report to Prevent Future Deaths – Andrew John Hughes

Thank you for your Regulation 28 Report dated 5 December 2025 regarding the sad death of Andrew John Hughes. On behalf of NHS Greater Manchester (NHS GM). We would like to begin by offering our sincere condolences to Andrew's family for their loss.

Thank you for highlighting your concerns during the inquest which concluded on the 13 November 2025. On behalf of NHS GM, we apologise that you have had to bring these matters of concern to our attention. We recognise it is very important to ensure we make the necessary improvements to the quality and safety of future services.

During the inquest you identified the following cause for concern: -

> **The inquest heard evidence that across Greater Manchester there is a system known as Right Care Right Person (RCRP). This is a system that has been adopted by Greater Manchester along with many other parts of England. The inquest was told that adoption of the system was overseen by the Office of the Deputy Mayor for Greater Manchester.**
>
> **The aim according to the evidence heard was to identify which agency was most appropriate to respond to concerns raised such as in the case of Mr Hughes. In this case Greater Manchester Police declined to attend and indicated it was a health matter and therefore a matter for the Ambulance Service.**
>
> **The evidence was that this was an incident that involved concerns around his mental health and the risks that his mental health presented to his wellbeing. It would, the inquest was told have been more appropriate for mental health services to have become involved rather than the ambulance service.**

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It was however unclear from the evidence how that would have been facilitated. There was no clarity as to what arrangements existed for a concerned family to be signposted by GMP to mental health services or how mental health services could be contacted in such an emergency situation as presented in this case or what response could have been expected. This was because it was unclear what provision there was in Greater Manchester for Mental Health Services to deal with these emergency situations.

We have reviewed the circumstances of the death included in your report and understand that immediately prior to Andrew's death, mental health services were not contacted. It is our understanding from your report that 999 services were contacted as Andrew required an emergency response. Mental health services commissioning by NHS in Greater Manchester would not provide a 999-emergency response, nor would they have the means to contact someone who is not responding to phone calls or be able to force entry to a property when there is a concern for an individual's safety.

It is not known whether signposting to mental health services, on the day in question, would have been able to prevent Andrew's death as this did not take place. However, I can confirm that we do have an agreed process, developed in partnership with Greater Manchester Police (GMP) for police call handlers to transfer and signpost people for whom there is a mental health concern for welfare. This is via NHS 111 option 2 which in GM is staffed by trained mental health professionals who provide triage and assessment over the phone for people experiencing mental health crisis. We have established a dedicated mental health team based in Northwest Ambulance Service (NWAS) Emergency Operations Centre that provides 24/7 support and tactical advice to police and ambulance teams 'at scene'. It is not clear from your report whether GMP contacted the team for tactical advice in this incident.

In addition to this, we have commissioned mental health crisis spaces in each borough in Greater Manchester that provide 'drop-in' access for people, and we are currently expanding our 24/7 crisis resolution and home-based treatment services across GM to better support people at home or in their place of residence when in crisis.

In your report you state that 'it was unclear what provision there was in Greater Manchester for mental health services to deal with these emergency situations'. It should be stressed that mental health services are commissioned by NHS GM to deliver a crisis mental health response, and not an emergency response, which is provided by 999 services. Based on the circumstances of the death, this report of concern required an emergency services response and as mental health services were not contacted immediately prior to Andrew's death, they could not have known about the immediate risk to life.

Unfortunately this tragic outcome highlights an ongoing risk that NHS GM has raised with, and is committed to addressing with, GMP colleagues in terms of their definition of 'immediate risk to life'. It is to our understanding that this should mean 'immediate risk to life, present and continuing' when a person is at significant or substantial risk of death at any time from that point onwards from when this risk is identified, until safeguarded.

We will ensure that the learning from this Prevention of Future Deaths report is shared through our existing system governance and across sectors and continue our work with our system partners, including the emergency services, to provide the best urgent and emergency care for the people of Greater Manchester.

I trust this information is useful. Please contact me should you require further information.

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Best wishes

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[redacted]
MBcHB MRCGP DRCOG DFFP PGCGPE
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