

REGULATION 28: REPORT TO PREVENT FUTURE DEATHS

| | |
|---|---|
| | <p>REGULATION 28 REPORT TO PREVENT FUTURE DEATHS</p> <p>THIS REPORT IS BEING SENT TO: Office of the Deputy Mayor of Greater Manchester Greater Manchester Integrated Care Board</p> |
| 1 | <p>CORONER</p> <p>I am Alison Mutch, Senior Coroner, for the coroner area of Manchester South</p> |
| 2 | <p>CORONER'S LEGAL POWERS</p> <p>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.</p> |
| 3 | <p>INVESTIGATION and INQUEST</p> <p>On 21st March 2025 I commenced an investigation into the death of Andrew John HUGHES. The investigation concluded at the end of the inquest on 13th November 2025. The conclusion of the inquest was suicide. The medical cause of death was 1a Hanging.</p> |
| 4 | <p>CIRCUMSTANCES OF THE DEATH</p> <p>On 18th March 2025 Andrew John Hughes was found [REDACTED] by Greater Manchester Police who attended his home address following a call indicating there was a risk to life. He declined to attend at hospital but agreed to go to his father's home address. Officers transported him there and his father was updated regarding the concerns. On 20th March at 21:48 a call was received by the ambulance service from a friend of his partner indicating they were concerned as the last contact had been at 7pm and attempts to contact him since then had been unsuccessful. The call had been made to the ambulance service because when the caller rang Greater Manchester Police at 21:38 on 20th March they were signposted to the ambulance service. This was because it did not fall within their definition of an immediate threat to life. However, because the concern related more to mental health, the caller should have been signposted to mental health services. It is not known what steps</p> |

| | |
|---|--|
| | <p>mental health services would have taken. The ambulance service categorised the call as category 3 (a response within 120 minutes in 90% of cases) under the national call categorisation formula. The call remained at this category level and an ambulance was dispatched at 00:23 to his home address. Entry could not be gained until the Greater Manchester Fire and Rescue Service attended to force entry. He was found deceased at [REDACTED]. There was no evidence of any activity by him on his phone since 18:52 on 20th March 2025.</p> |
| 5 | <p><u>CORONER'S CONCERNS</u></p> <p>During the course of the inquest the evidence 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.</p> <p>The MATTERS OF CONCERN are as follows. –</p> <p>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.</p> <p>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.</p> <p>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.</p> <p>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.</p> |
| 6 | <p>ACTION SHOULD BE TAKEN</p> |

| | |
|---|---|
| | <p>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.</p> |
| 7 | <p>YOUR RESPONSE</p> <p>You are under a duty to respond to this report within 56 days of the date of this report, namely by Friday 30th January 2026. I, the coroner, may extend the period.</p> <p>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.</p> |
| 8 | <p>COPIES and PUBLICATION</p> <p>I have sent a copy of my report to the Chief Coroner</p> <p>I am also under a duty to send the Chief Coroner a copy of your response.</p> <p>The Chief Coroner may publish either or both in a complete or redacted or summary form. They may send a copy of this report to any person who they believe 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.</p> |
| 9 | <p>5th December 2025</p> <p></p> <p>HM Senior Coroner Alison Mutch</p> |