

**REPORT TO PREVENT FUTURE DEATHS
REGULATION 28 OF THE CORONERS (INVESTIGATIONS) REGULATIONS 2013**

1.	<p>CORONER I am Chris Morris, Area Coroner, for the coroner area of Greater Manchester (South)</p>
2.	<p>DATE OF REPORT 30 April 2026</p>
3.	<p>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.</p>
3.	<p>THIS REPORT IS BEING SENT TO The Secretary of State for Health and Social Care.</p> <p>You are under a duty to respond to this report within 56 days of the date of this report, namely by 25 June 2026. I, the coroner, may extend the period if an appropriate application is made.</p>
4.	<p>YOUR RESPONSE 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> <p>I have a duty to send a copy of your response to the Chief Coroner.</p> <p>In accordance with the Chief Coroner's Publication Policy, you should send me any representations regarding publication of your response. These representations should be made at the same time as the response is provided. I will pass any representations received to the Chief Coroner for a decision.</p> <p>Please note any links to webpages included in the response will not be checked for sensitive information prior to publication, as the information is already online.</p> <p>The names of those who do not respond to PFD reports are regularly published on the Chief Coroner's webpages Non-responses to Prevention of Future Death (PFD) reports - Courts and Tribunals Judiciary.</p>

5.	<p>SUMMARY OF CORONER’S CONCERN</p> <p>This report is made in respect of a range of concerns arising from the evidence relating to provision of healthcare services for patients identified as having co-occurring conditions (dual diagnosis), unrestricted availability of alcohol via online delivery Apps and the ongoing absence of a unified digital NHS healthcare records system in England and Wales.</p>
6.	<p>ACTION SHOULD BE TAKEN</p> <p>In my opinion unless action is taken to address the above concerns then there is a significant risk of future deaths and I believe each of you have the power to take such action.</p>
7.	<p>INVESTIGATION AND INQUEST</p> <p>On 23 June 2025, I commenced an investigation into the death of Joseph William Cooper who died outside his home aged 28 years.</p> <p>The medical cause of Mr Cooper’s death was determined at inquest to have been:</p> <p style="padding-left: 40px;">1)(a) Multiple traumatic injuries and profound acute alcohol and drug intoxication</p> <p style="padding-left: 40px;">II Depression and Alcohol Dependence Syndrome (Co-occurring conditions).</p> <p>At the end of the inquest, I recorded the following Narrative Conclusion:</p> <p><i>‘Mr Cooper died as a consequence of complications arising from injuries sustained in a fall from a height and profound intoxication in the context of unmet mental health needs.’</i></p>
8.	<p>CIRCUMSTANCES OF DEATH</p> <p>Mr Cooper died on 19 June 2025 outside his home having sustained multiple traumatic injuries in a fall which occurred after he had placed himself outside his third-floor window whilst profoundly intoxicated. Mr Cooper’s death was contributed to by the co-occurring conditions of depression and alcohol dependence syndrome.</p>

9.

CORONER'S CONCERNS

During the course of the inquest, I heard evidence 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:

- 1) The court heard evidence that at the time of his death, Mr Cooper had unmet mental health needs principally as a consequence of no specific service or treatment pathway existing locally which would provide wholistic and co-ordinated care for co-occurring mental health and substance misuse conditions (also known as 'dual diagnosis'). I am concerned as to the lack of availability of commissioned services to provide care for patients with co-occurring mental health and substance misuse conditions both in this and other areas.
- 2) Mr Cooper was able to order large quantities of alcohol via online delivery services and have them delivered to his door quickly, including on occasions when he was already obviously intoxicated. I am concerned that large quantities of alcohol are so quickly and readily available from a range of retailers via online delivery services with only basic age-verification checks being undertaken.
- 3) The court heard evidence that professionals from the drug and alcohol service treating Mr Cooper had no access to his mental health records despite both mental health and drug and alcohol services being provided under the auspices of the same NHS Foundation Trust.

Whilst the court heard that Pennine Care NHS Foundation Trust is urgently seeking to grant viewer access to relevant patients' mental health records to the drug and alcohol team, it is a matter of concern that no complete and unified digital NHS health records system currently exists within England and Wales.

10. **COPIES AND PUBLICATION OF THIS REPORT**

I have a duty to send a copy of my report to every Interested Person who in my opinion should receive it.

I also may send a copy of the report to any other person who I believe may find it useful or of interest.

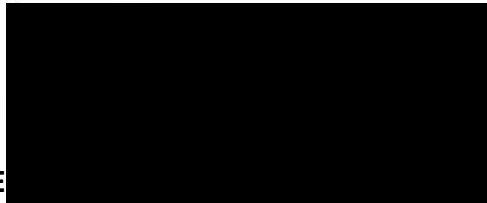
I can confirm I have sent the report to:

1. Mr Cooper's family
2. Pennine Care NHS Foundation Trust
3. The Disclosure and Barring Service
4. North West Ambulance Service NHS Foundation Trust
5. Greater Manchester Integrated Care Board
6. Stockport Metropolitan Borough Council

I also have a duty to send a copy of the report to the Chief Coroner.

You may make representations to me, the coroner, about the publication of the contents of this report in line with Chief Coroner's [PFD Publication Policy \(2026\)](#). Any representations will be sent to the Chief Coroner alongside the report. Please refer to box 4 above for additional information relating to the publication of reports and responses.

SIGNATURE



HM Area Coroner Manchester South