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

Please do not include any living persons' names in this document, in accordance with the Chief Coroner's PFD Publication Policy (2026).

CORONER
I am Alison Mutch, Senior Coroner, for the coroner area of Greater Manchester South.

DATE OF REPORT
26 August 2026

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.

THIS REPORT IS BEING SENT TO:
1. Home Secretary
2. College of Policing

You are under a duty to respond to this report within 56 days of the date of this report, namely by **21 October 2026**. I, the coroner, may extend the period if an appropriate application is made.

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.

I have a duty to send a copy of your response to the Chief Coroner.

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.

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.

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.

SUMMARY OF CORONER'S CONCERN

See below

ACTION SHOULD BE TAKEN

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.

INVESTIGATION AND INQUEST

On 5th January 2026, I commenced an investigation into the death of Thomas Crabbe date of birth 8th October 1947.

The medical cause of death was:

1a) Hypothermia; and II) Ischaemic heart disease and bronchopneumonia

Conclusion- Narrative: Died from hypothermia having fallen to the floor in his flat which was not warm and when he was not able to call for assistance.

CIRCUMSTANCES OF DEATH

Thomas Crabbe was a 78-year-old man with limited mobility living alone in a social housing flat designated for the over 60s. A family friend became concerned when she was unable to contact him after 27th December 2025. She did not have a key but made several visits to try to contact him. Her concern increasing, she contacted Greater Manchester Police on 1st January to ask for help. She was told that as she could not see him within the flat that it was not a police matter. The advice was to call Stockport Homes when they reopened the next day, or it might be worth trying the ambulance service. The following day Stockport Homes were contacted as soon as they reopened. They went to the property and forced entry due to their significant concerns for his welfare following the information given. Thomas Crabbe was found deceased on the floor of the living room of the flat. He had probably been dead for several days. A post-mortem confirmed he had died of hypothermia.

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:

Greater Manchester Police dealt with the concerns raised in relation to Mr Crabbe under Right Care Right Person which has been adopted by Police Forces nationally to reduce the number of incidents that police officers attend.

The particular concerns that arose in relation to Right Care Right Person and how it is used/interpreted by Forces and the risk of future deaths arose in relation to several issues:

1. In this situation the Court was told that Police would have attended had the friend been able to see he was in the flat. However, Mr Crabbe could not in reality have been anywhere else given what was known about him and the information shared.

2. It was accepted in evidence that if GMP are not attending then effective signposting is essential. In this situation the Polce were saying it was a health matter rather than a police matter and that NWAS were the correct organisation. This was not made clear by the call handler. The police on their review did not identify the quality issue relating to signposting.

3. The internal Police review identified that the friend should have been told to call hospitals etc. However, it was accepted in evidence that such advice would in reality have not helped as a hospital is bound by GDPR and it was unlikely that such information would have been given out. It was unclear why such advice was seen as appropriate when a concern for welfare was being raised and if it should be given by Police Forces.

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: The Executor

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

