## REGULATION 28: REPORT TO PREVENT FUTURE DEATHS

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	THIS REPORT IS BEING SENT TO: The Chief Constable, Greater Manchester Police
1	CORONER
	I am John Pollard, senior coroner, for the coroner area of South Manchester
2	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
3	INVESTIGATION and INQUEST
	On 16 <sup>th</sup> January 2015 I commenced investigations into the deaths of Yvonne Davies dob 13 <sup>th</sup> June 1968 and Andrew Francis Davies dob 9 <sup>th</sup> October 1969. The investigations concluded on the 24 <sup>th</sup> June 2015 and the conclusion in relation to Yvonne Davies was one of "Unlawfully killed" and of Andrew Davies was one of "Took his own life". The medical cause of death of Yvonne Davies was 1a Stab wounds to the neck and the medical cause of death of Andrew Davies was 1a Hanging.
	CIRCUMSTANCES OF THE DEATH Andrew Davies was under the impression that his wife was having a sexual relationship with another man and so he stabbed her in the neck and beat her over the head with a hammer. He then went to the loft hatch in their house and he hanged himself from the loft.
	CORONER'S CONCERNS
	During the course of the inquest the evidence revealed matters giving rise to concern. In my opinion there is a risk that future deaths will 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 person with whom Mrs Davies was alleged to be having an affair, is a
	serving GM police officer (he admitted the affair in evidence) and despite the fact that he was off-duty, he was first to the scene of these deaths and using powers under the Police and Criminal evidence Act he broke in to the house. He then proceeded to move around the house, using the sleeve of his pullover when opening doors. By so doing he contaminated the scene for DNA etc.
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6	ACTION SHOULD BE TAKEN
	In my opinion action should be taken to prevent future deaths and I believe you have the power to take such action.
7	YOUR RESPONSE
	You are under a duty to respond to this report within 56 days of the date of this report, namely by 1 <sup>st</sup> September 2015. I, the coroner, may extend the period.
	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.
3	COPIES and PUBLICATION
	I have sent a copy of my report to the Chief Coroner and to the following Interested Persons namely Sister of Andrew Davies) and Yvonne Davies).
	I am also under a duty to send the Chief Coroner a copy of your response.
	The Chief Coroner may publish either or both in a complete or redacted or summary form. He may send a copy of this report to any person who he believes 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.
	7 <sup>th</sup> July 2015 John Pollard, HM Senior Coroner