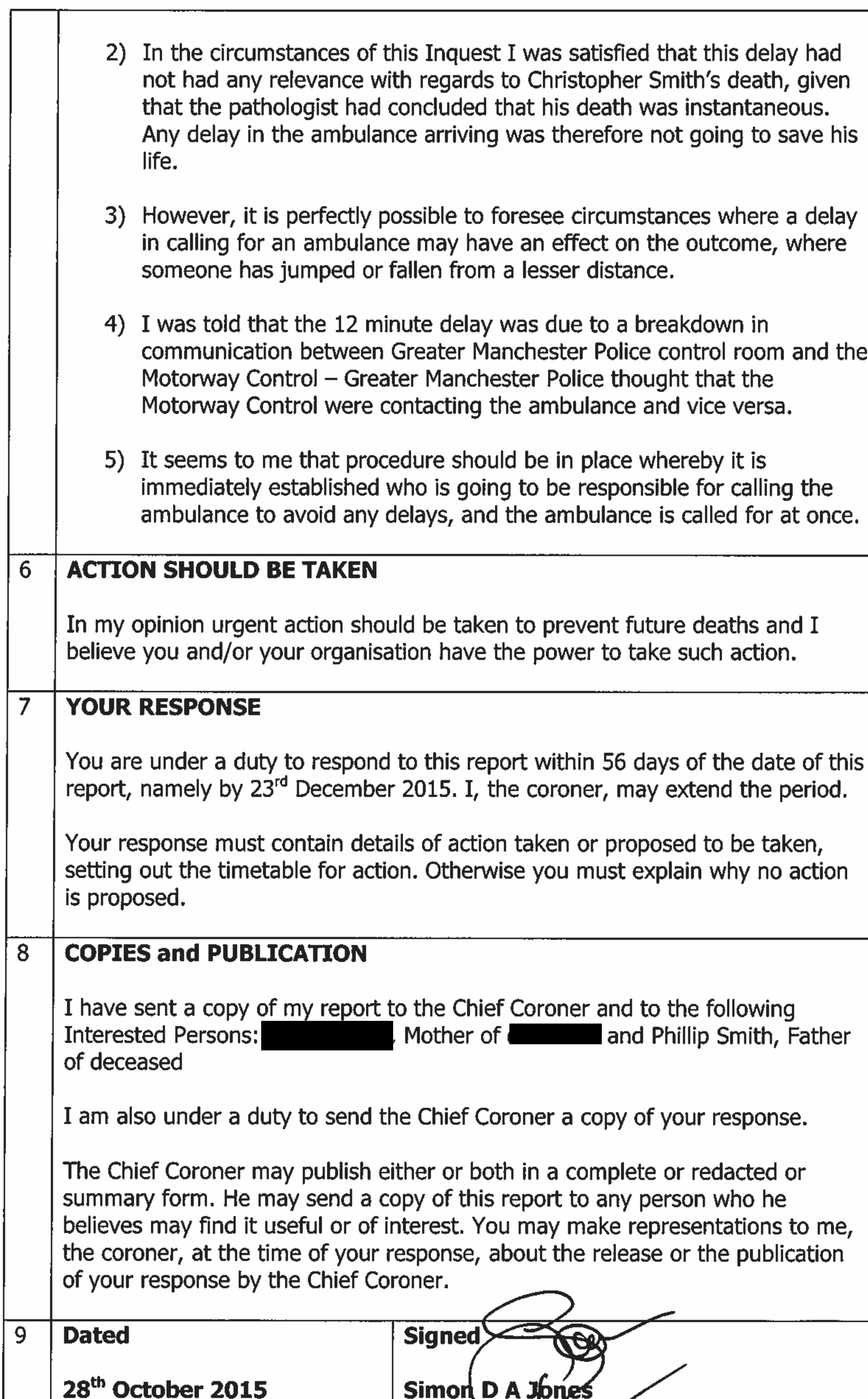
REGULATION 28: REPORT TO PREVENT FUTURE DEATHS (1)

*NOTE: This form is to be used **after** an inquest.*

	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO:** **1.** Ian Hopkins, Chief Constable, Greater Manchester Police
1	**CORONER** I am Simon David Allen Jones, H M Assistant Coroner , for the Coroner Area of Manchester West
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 22nd July 2015 I commenced an investigation into the death of Christopher John Smith, born on 27th December 1979. The investigation concluded at the end of the inquest on 21st October 2015. The medical cause of death was 1a) Multiple Injuries. The conclusion of the inquest was that Christopher John Smith committed suicide.
4	**CIRCUMSTANCES OF THE DEATH** On the 15th July 2015 the deceased, Christopher John Smith was seen driving his motor vehicle across Barton Bridge in a northbound direction. He stopped the car on the left hand side of the inner lane, exited the vehicle and climbed over the railings. Witnesses confirmed that he did not pause or hesitate, before jumping from the bridge to the rough ground below. He was confirmed dead at the scene and the pathologist who gave evidence at the Inquest confirmed that in his view, on a balance of probabilities, Christopher John Smith's death would have been instantaneous.
5	**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) It was clear from the evidence that there was a 12 minute delay in the police contacting the ambulance – the police were notified of the incident but did not contact North West Ambulance Service immediately.



	2) In the circumstances of this Inquest I was satisfied that this delay had not had any relevance with regards to Christopher Smith's death, given that the pathologist had concluded that his death was instantaneous. Any delay in the ambulance arriving was therefore not going to save his life. 3) However, it is perfectly possible to foresee circumstances where a delay in calling for an ambulance may have an effect on the outcome, where someone has jumped or fallen from a lesser distance. 4) I was told that the 12 minute delay was due to a breakdown in communication between Greater Manchester Police control room and the Motorway Control – Greater Manchester Police thought that the Motorway Control were contacting the ambulance and vice versa. 5) It seems to me that procedure should be in place whereby it is immediately established who is going to be responsible for calling the ambulance to avoid any delays, and the ambulance is called for at once.
6	**ACTION SHOULD BE TAKEN** In my opinion urgent action should be taken to prevent future deaths and I believe you and/or your organisation 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 23rd December 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.
8	**COPIES and PUBLICATION** I have sent a copy of my report to the Chief Coroner and to the following Interested Persons: [redacted], Mother of [redacted] and Phillip Smith, Father of deceased 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.
9	**Dated** **28th October 2015**
	Signed **Simon D A Jones**