## REGULATION 28: REPORT TO PREVENT FUTURE DEATHS

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| | **REGULATION 28 REPORT TO PREVENT FUTURE DEATHS**<br><br>**THIS REPORT IS BEING SENT TO: The Chief Constable, Greater Manchester Police: The North West Ambulance Service: Secretary of State for Health: NHS England:** |
| 1 | **CORONER**<br><br>I am John Pollard, senior coroner, for the coroner area of South Manchester |
| 2 | **CORONER'S LEGAL POWERS**<br><br>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**<br><br>On 23rd December 2014 I commenced an investigation into the death of **Christopher Philip Fields** dob 7th March 1977.The investigation concluded on the 11th April 2016 and the conclusion was one of **Unlawful killing**. The medical cause of death was 1a Head Injury. |
| 4 | **CIRCUMSTANCES OF THE DEATH**<br>**On the 12th December 2014 he was in his home address when he was attacked on two separate occasions, and during the second such attack he sustained fatal head injuries.** |
| 5 | **CORONER'S CONCERNS**<br><br>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.<br><br>The **MATTERS OF CONCERN** are as follows. –<br><br>1. **The police were called to the address after the first assault had occurred and were still in attendance when the assailant re-entered the premises via the broken window, which he had smashed out of its frame when entering the first time. Despite this rather bizarre set of occurrences, the police then decided to leave the deceased before the ambulance service arrived. Sometime later, the assailant re-entered the flat and beat the deceased to his death.**<br>**Various issues arise as a result of the police actions, being why did they leave a vulnerable person in this manner, why did they not await the arrival of the ambulance, why did they not take the witness (female) who was there at the time to a place where she could give them details out of the earshot of the assailant etc., why did they leave an injured and/or intoxicated person in the sole care of another who was also intoxicated, why did they consider it appropriate to accept the view of the injured/intoxicated person as to whether it was safe to leave him in the situation in which he was found?**<br>**Are there issues of training for all GMP officers or did the officers fail to** |

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| | **adhere to the approved guidance? (POLICE)**<br><br>2. **The calls (999) to the ambulance service were properly coded and applied by the call-taker leading to a Green 2 response. This should have led to a vehicle attending within 20 minutes. In the event, the vehicle did not arrive for 2 hours 8 minutes. Why was the response time so dramtically lengthier than prescribed and is this a matter of resources? (NWAS)**<br>3. **The fact that the call taker coded the call properly and yet this case involved a patient who was clearly critically injured and despite that fact it still did not generate a Red response, suggests that the algorithms used for coding are not accurate and not fit for purpose. In my view this is an extremely serious flaw and may/will lead to future deaths occurring unless it is remedied. (NWAS, SECRETARY OF STATE and NHS ENGLAND)** |
| 6 | **ACTION SHOULD BE TAKEN**<br><br>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**<br><br>You are under a duty to respond to this report within 56 days of the date of this report, namely by 13th July 2016. I, the coroner, may extend the period.<br><br>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**<br><br>I have sent a copy of my report to the Chief Coroner and to the following Interested Persons namely [redacted]. I have also sent it to Clifford Johnston and Co., solicitors for the family of the deceased, who may find it useful or of interest.<br><br>I am also under a duty to send the Chief Coroner a copy of your response.<br><br>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 | **18.5.16** **John Pollard, HM Senior Coroner** |
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