REGULATION 28: REPORT TO PREVENT FUTURE DEATHS

	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS THIS REPORT IS BEING SENT TO: Rt Hon. Nadhim Zahawi, Secretary of State for Education
1	CORONER I am Alison Mutch , Senior Coroner, for the Coroner Area of Greater Manchester South
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 4th March 2019 I commenced an investigation into the death of Yousef Ghaleb Makki. The investigation concluded on the 17th November 2021 and the conclusion was one of Narrative: Died from complications of a stab wound to the chest, the precise circumstances in which he was wounded cannot on the balance of probabilities be ascertained. The medical cause of death was 1a stab wound to the chest.
4	CIRCUMSTANCES OF THE DEATH On 2nd March 2019 whilst on Gorse Bank Road Yousef Makki was stabbed in the chest. He died at Manchester Royal Infirmary on 2nd March 2019 from the single stab wound to the chest.
5	<u>CORONER'S CONCERNS</u> 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. The inquest heard evidence that there was a culture amongst some teenagers who saw the possession of knives as being impressive and did not understand the risks that are inherent in the carrying of knives.

	The knife that Yousef was stabbed with was a [redacted] that had been purchased with ease [redacted] during break time at school. It was clear from the evidence that schools and education play a vital role in attitudes to carrying knives by teenagers.
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 25th February 2022. 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 namely the family, [redacted], [redacted], the IOPC and Greater Manchester Police, who may find it useful or of interest. 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	31st December 2021  **Alison Mutch** **HM Senior Coroner**