REGULATION 28: REPORT TO PREVENT FUTURE DEATHS

	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS THIS REPORT IS BEING SENT TO: Chief Executive of LTE Group, Chief Executive of IMI (Institute of the Motor Industry)
1	CORONER I am Alison Mutch, 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 21st March 2017 I commenced an investigation into the death of Leigh William Wilde. The investigation concluded on the 19th January 2018 and the conclusion was one of suicide. The medical cause of death was; 1a) Hanging
4	Leigh William Wilde had raised concerns about issues at his workplace. He received a letter from his employer on 16th March 2017 having previously been suspended on 13th March 2017. Later on 16th March 2017, Leigh William Wilde was found suspended from a ligature at his home address, [redacted]
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. – • Leigh William Wilde had been suspended from his employment shortly before his death. There was no supporting documentation to set out the rationale for the decision. There was no evidence of risk factors or how to minimise them being considered when deciding whether to suspend an employee under the company policy. • There were no notes available for the meeting on 13th March or

	evidence of consideration/discussion of risk at that meeting. There was no evidence that he had been referred to or reminded of the support services available to him. • The approach of both LTE and IMI towards whistleblowers and support for them was unclear.
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 7th May 2018. 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 1) [redacted] wife of the deceased 2) 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	**Alison Mutch OBE** **HM Senior Coroner** **12/03/2018**