REGULATION 28: REPORT TO PREVENT FUTURE DEATHS

	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS THIS REPORT IS BEING SENT TO: Chief Constable of Greater Manchester Police, Chief Executive of The College of Policing and Home Office
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 14th December 2017, I commenced an investigation into the death of Dane Lee Pearson. The investigation concluded on the 14th January 2019 and the conclusion was one of suicide. The medical cause of death was 1a hanging
4	Dane Lee Pearson had a history of mental health problems. He had been diagnosed with depression with psychotic type symptoms. These were exacerbated by his use of amphetamine. He was under the care of the Early Intervention team and the Community Mental Health Team. On 27th November 2017, Greater Manchester Police decided to no further action on evidential grounds a criminal offence. That decision was not communicated to him. On 30th November 2017, Greater Manchester Police served a Child Abduction Warning Notice on him where the process set out in Greater Manchester Police guidance had not been followed. No risk assessment had taken place. On 13th December 2017, Dane Pearson was found suspended from a ligature at his home address 13 Newton Terrace, Dukinfield. Toxicology showed evidence of excessive use of amphetamine, prior to death. There were no suspicious circumstances or evidence of third party involvement in his death.
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. – The inquest heard that: 1. In this case, the CAWN had been issued on limited evidence particularly regarding identification. In addition, it had been issued many months after the allegation and after the authorisation. The inquest was told that the process had not been followed relating to timeliness. There was no

	documentation in existence explaining the rationale for the issuing of the CAWN. 2. In issuing, the CAWN there was no evidence that his known vulnerability had been taken into account. A risk assessment had not been carried out. In this case, officers attended at his home address and served the CAWN on him .He refused to sign it on the basis; he had no knowledge of it or the circumstances behind it. It was left with him with no clarification about what if any steps he could take in relation to it. The inquest heard evidence that he was deeply worried about it and the impact of it on his life. 3. The inquest heard that OPUS the Police system did not appear to have been correctly updated with markers to flag his vulnerability. 4. The inquest was told that he was placed under investigation for a suspected attempt burglary and possession of an offensive weapon. A decision was taken by the OIC and his sergeant that it should be NFAD. The decision was not communicated to Mr Pearson. The officer had not followed the process for notification of decisions to those under investigation. As a result, at the time of his death he believed he may be charged with a criminal offence.
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 12th April 2019. 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 [redacted] mother of the deceased, 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, 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 15th August 2019