REGULATION 28: REPORT TO PREVENT FUTURE DEATHS

	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS THIS REPORT IS BEING SENT TO: Greater Manchester Police
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 7th August 2020 I commenced an investigation into the death of Robert Hardy. The investigation concluded on the 22nd January2021 and the conclusion was one of suicide. The medical cause of death was 1a) hanging.
4	CIRCUMSTANCES OF THE DEATH On 6th August 2020, Robert Stephen Hardy was found at his home Address [redacted] suspended from a ligature. The inquest heard that Robert Hardy had mental health issues in the months preceding his death. On 25th July he had reported an attempt to take his life to GMP and had been taken to hospital by Police Officers. On 30th July he had reported an alleged assault to GMP involving a male he named and involving a weapon. The inquest heard that officers did not visit him to take an account and he was not signposted to any support services. The assault was not recorded as a crime by GMP until after his death. It was accepted in evidence that he was a vulnerable victim given his recent history. The inquest heard that in the

	hours before his death he had telephoned GMP in response to the text message but ended the call.
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 evidence before the inquest was that GMP had not recorded the assault with a weapon as a crime within the crime recording system. It was accepted that this should have happened. The concern arises in relation to the impact this then had on the provision of and signposting of him to appropriate victim support given his recognised and known vulnerabilities.
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 8th April 2021. 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 persons namely [redacted], Father of Mr. Robert Hardy, HM Inspectorate of Constabulary, Victims Commissioner for England 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, Senior Coroner, for the Coroner Area of Greater Manchester South** **11/02/2021**