Regulation 28: REPORT TO PREVENT FUTURE DEATHS

NOTE: This form is to be used **after** an inquest.

	REGULATION 28 REPORT TO PREVENT DEATHS **THIS REPORT IS BEING SENT TO:** **1. Chief Constable of Cheshire police** **2. National College of Policing** **3. National Police Chiefs' Council**
1	**CORONER** I am Charlotte KEIGHLEY, Assistant Coroner for the coroner area of Cheshire
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 08 November 2017 I commenced an investigation into the death of John George CONDRON aged 53. The investigation concluded at the end of the inquest on 25 September 2023. The conclusion of the inquest was that: Narrative Conclusion - John George Condron took his own life whilst suffering extreme anxiety and stress in respect of allegations made against him which were being investigated by the police. This was exacerbated by i) him not having been informed that no further action was to be taken in respect of the most serious allegation against him, despite that decision having been made 10 days previously; and ii) no enquiries having been made in respect of evidence he referred to in his police interviews.
4	**CIRCUMSTANCES OF THE DEATH** On the 2nd November 2017, John Condron was found at his home address suspended from the roof beams in his loft by a ligature around his neck made from a rope. At the time of his death he was under investigation by the Police, allegations having been made against him by his ex-partner but prior to these allegations being made, Mr Condron had reported to the police that he was the victim of domestic abuse by that same partner. Mr Condron had been interviewed by the police on three separate occasions in relation to two different allegations. On the 23rd October 2017 the decision was made to take no further action in relation to the most serious of those allegations. Mr Condron had not been informed of that decision which exacerbated the extreme anxiety and stress he was experiencing at the time of his death.
5	**CORONER'S CONCERNS** During the course of the inquest, evidence revealed matters giving rise to concern. In my opinion there is a risk that future deaths could occur unless action is taken. In the circumstances it is my statutory duty to report to you. **The MATTERS OF CONCERN are as follows:-** (1) I received evidence confirming the absence of any agreed protocol relating to

	timescales for a suspect to be informed by the police of a decision to take no further action in respect of allegations made against them. At the conclusion of the Inquest, it was confirmed that this was the position both at the time of Mr Condron's death in November 2017 and at the conclusion of the Inquest in September 2023. (2) I received evidence that at a National Level, the Victim's Code of Practice provides that a victim has a right to be informed of key decisions in an investigation within 5 working days, or within 1 working day if they are eligible for Enhanced Rights. This includes a decision by the police to take no further action in respect of the allegations they have made. There is no such code of practice in respect of informing suspects of the same. (3) I have concerns that further self-inflicted deaths will occur in circumstances where a suspect is not informed, within a specified time period, of a decision to take no further action in respect of allegations made against them.
6	**ACTION SHOULD BE TAKEN** In my opinion action should be taken to prevent future deaths and I believe you (and/or your organisation) 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 December 01, 2023. 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 I have also sent it to: The Chief Coroner; The family of John George Condron Chief Constable of Cheshire Police National College of Policing National Police Chiefs' Council who may find it useful or of interest. I am also under a duty to send a copy of your response to the Chief Coroner and all interested persons who in my opinion should receive it. I may also send a copy of your response to any person who I believe may find it useful or of interest. 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	**Dated: 06/10/2023**

	 **Charlotte KEIGHLEY** **Assistant Coroner for** **Cheshire**