Kirsty Gomersal | Acting Senior Coroner | Cumbria

Fairfield, Station Road, Cockermouth, Cumbria CA13 9PT

Tel: [redacted] | **Email:** [redacted]

Case Ref: [redacted]

8th January 2025

REGULATION 28 REPORT TO PREVENT FUTURE DEATHS

THIS REPORT IS BEING SENT TO:

1) [redacted], Secretary of State for Justice

2) [redacted], Staff Officer to National Police Chiefs Council

3) [redacted], CEO College of Policing

CORONER

1 I am Dr Nicholas Shaw, HM Assistant Coroner for Cumbria

CORONER'S LEGAL POWERS

2 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.

http://www.legislation.gov.uk/ukpga/2009/25/schedule/5/paragraph/7

http://www.legislation.gov.uk/uksi/2013/1629/part/7/made

INVESTIGATION and INQUEST

3 On 1st May 2024 I commenced an investigation into the death of Matthew BRIERLEY, aged 39. The investigation concluded at the end of the inquest on 16th December 2024 . The short form conclusion of the inquest was one of Suicide

Medical cause of death was 1a Asphyxia

CIRCUMSTANCES OF THE DEATH

The record of inquest was as follows: "Matthew Brierley died in the carpark of Buttermere Court Hotel, Buttermere, Cumbria on 24th April 2024. He was under great personal stress due to a police investigation and bail conditions imposed. It is most likely that this stress caused him to take his own life by [redacted] asphyxiation".

4 Matthew had been arrested at his home in Fareham on 16th March, Hampshire police having received information that he was linked to a Paypal account used to purchase indecent images of children in 2023. Matthew denied the allegation in a "no comment" interview and was bailed pending enquiries and examination of his computer and mobile devices. Bail conditions precluded him from living or sleeping at home or having any unsupervised contact with his biological children or stepdaughter. His employers the Border Force were also informed and Matthew was suspended from work. On 23rd April Matthew left Hampshire driving north to Buttermere, a place that had special meaning for him. The following morning he was found deceased in his car [redacted]. He left several final messages in his car.

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. –

[BRIEF SUMMARY OF MATTERS OF CONCERN]

(1) It is recognized that men in Matthew's circumstances are at a markedly elevated risk of suicide. Several papers refer to this - I found Kothari et al (Journal of Forensic and Legal Medicine, July 2021) particularly informative. They quote 3.2% of those arrested in operation Notarise committing suicide and explore reasons why this group is particularly vulnerable.

5 (2) I was told that when released on bail Matthew was informed that examination of devices and a decision in his case might take up to 18 months. Being suspended from work and unable to live at home removed normality and stability from Matthew and likely impaired his ability to cope with his situation. The length of time taken to reach a decision seems excessive, prolonging the time Matthew would be at risk. I was told devices can be "triaged" within a matter of days or more quickly, surely cases such as this should be dealt with more expeditiously? It seems that "standard" bail conditions are applied but I am not aware of any suggestion of a specific risk to Matthew's stepdaughter, might a more detailed individual assessment of risk be helpful? I should record that Matthew's phone was examined after his death and that images found were not of a grade that would have led to a prosecution.

(3) Police acknowledged the increased risk and completed a standard assessment form when Matthew was released - he denied any risk and also declined referral to Liaison and Diversion service. A Family Contact Officer was also appointed but the onus remained on Matthew to seek help and there was no proactive contact which might have been helpful as men in Matthew's situation are less likely to seek help due to feelings of shame and embarrassment.

ACTION SHOULD BE TAKEN

6 In my opinion action should be taken to prevent future deaths and I believe you and our organizations have the power to take such action.

YOUR RESPONSE

You are under a duty to respond to this report within 56 days of the date of this report,
7 namely by 5th March 2025. 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.

COPIES and PUBLICATION

I have sent a copy of my report to the Chief Coroner and to the following Interested Persons Matthew's widow and father. I have also sent it to DI [redacted] of Hampshire Constabulary who may find it useful or of interest.

8 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.

8th January 2025

9 Signature 

Dr Nicholas Shaw, HM Assistant Coroner for Cumbria