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, Cleveland Police Legal Department**
1	**CORONER** I am Clare Bailey, HM Senior Coroner for the coroner area of Teesside & Hartlepool
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 06 June 2022 I commenced an investigation into the death of Grant Nicholas LOWRY aged 20. The investigation concluded at the end of the inquest on 26 March 2026. The jury made the following determinations: Grant had a diagnosis of ADHD, Anxiety and Depression which contributed to the circumstances surrounding his death. Non prescription drugs may have also contributed and affected his behaviour. He was known to mental health services where there were missed opportunities to provide further input into Grant's mental health. He left the family home 01.06.2022 in good spirits with his bag giving no cause for concern. Subsequently this changed when his mother received a worrying text message and alerted the Police. This led to an unsatisfactory and uncoordinated search with missed opportunities and incomplete records that delayed the discovery Grant. Grant hanged himself [redacted] and was found on 03.06.2022. The conclusion of the inquest was: Suicide whilst the balance of his mind was disturbed, in the context of a mental illness.
4	**CIRCUMSTANCES OF THE DEATH** Grant left his family home in the evening of 01.06.22 saying he was going to [redacted] in Hartlepool. Approximately forty minutes later he sent his mum a text message which indicated suicidal intent. His mother reported this to the police. The Police attended Summerhill Park and arranged for NPAS to attend. NPAS identified two heat sources, both of which were relayed to the police before leaving. NPAS directed officers to the first heat source. The Officer was unable to reach the heat source. The heat source was not recorded accurately nor was the officer's inability to reach the heat source. The second heat source was not heeded, was not recorded and was not searched. The Police were unable to contact their own POLSA. At around midday on 02.06.22 the police contacted mountain rescue, arranged their own dogs to attend and requested POLSA via mutual aid. Grant was located deceased by a dog walker in the early hours of 03.06.22.
5	**CORONER'S CONCERNS** During the course of the investigation my inquiries 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:

	(brief summary of matters of concern) There were issues with communication and record keeping which impacted on the quality and effectiveness of the searches undertaken. Some prevented re-tasking of further and full searches of the heat sources, to include: 1. The location of the first NPAS heat source was not recorded accurately. 2. The outcome of the search into the first NPAS heat source was not recorded accurately by the Officers involved or the call handler, whether in an Officer's day book, or on the STORM log, OEL or CAD. This prevented re-tasking of a search at that area. 3. The details of the second NPAS heat source were not heeded, whether by the Officers at Summerhill Park, the call handler or listening Supervision. This meant the heat source was not searched or recorded. 4. There was no liaison between Hartlepool and Stockton officers during the search at Summerhill Park on the evening of 01.06.22. This contributed to an unorganised and uncoordinated search. 5. There was inaccurate recording of which fields around [redacted] had been searched, which was relied upon by Supervision and prevented later searches of those areas. 6. The family were told that no heat sources had been identified by NPAS. 7. There were delays in requesting Polsa Mutual Aid from neighbouring police forces. 8. There were delays in requesting the involvement of Mountain Rescue(with their dogs) and the police dog unit. In addition, the officer who was guided by NPAS to the first heat source did not have a full set of operational PPE for a search at night time in a dense area. The batteries on his torch and work mobile phone were flat.
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 May 25, 2026. 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 : NPAS, Tees Esk & Wear Valley Trust, Mr Lowry's family 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: 30 March 2026** [redacted] **C Bailey** **HM Senior Coroner for Teesside & Hartlepool**