





## Regulation 28: REPORT TO PREVENT FUTURE DEATHS

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

	<p><b>REGULATION 28 REPORT TO PREVENT DEATHS</b></p> <p><b>THIS REPORT IS BEING SENT TO:</b></p> <p><b>1 The Chief Constable Greater Manchester Police</b></p>
<b>1</b>	<p><b>CORONER</b></p> <p>I am Michael James PEMBERTON, Area Coroner for the coroner area of Manchester West</p>
<b>2</b>	<p><b>CORONER'S LEGAL POWERS</b></p> <p>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.</p>
<b>3</b>	<p><b>INVESTIGATION and INQUEST</b></p> <p>On 10 January 2025 I commenced an Investigation into the death of Ruslans BURKEVICS aged 33. The investigation concluded at the end of the inquest on 06 March 2026. The conclusion of the inquest was a narrative that:</p> <p>Ruslans Burkevics died as a consequence of multiple injuries sustained in a fall from height, the exact circumstances of which were not directly witnessed and cannot be ascertained on the available evidence.</p> <p>The medical cause of death was Multiple injuries.</p>
<b>4</b>	<p><b>CIRCUMSTANCES OF THE DEATH</b></p> <p>Ruslans Burkevics died on 7th January 2025 at Royal Albert Edward Infirmary Wigan, after being found outside his home address Flat 75 Boyswell House, Wigan with multiple injuries having likely experienced an unwitnessed fall from an open 12th floor bedroom window. He had a history of self-harm and drug induced psychosis, but there was insufficient evidence to determine the precise circumstances of the fall from height.</p> <p>He had contact with officers from Greater Manchester Police the evening before he was discovered on the ground outside an open window of his flat. He had been escorted home by officers with his agreement after being reported to have been running into traffic in the locality. He was taken to his flat at around 22:55 on the 6<sup>th</sup> January 2025.</p>
<b>5</b>	<p><b>CORONER'S CONCERNS</b></p> <p>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.</p> <p>The <b>MATTERS OF CONCERN</b> are as follows:</p> <p>1 - During the course of evidence it was heard that the deceased had contact with officers from Greater Manchester Police on the night before he was found having apparently suffered a fall from height outside his home address. There was no causative or contributory link established on the evidence and officers actions the previous evening were appropriate.</p>



	<p>2 - The deceased had a history of mental health difficulties and use of substances which contributed to episodes of mental health crisis. Police had on other occasions utilised powers under the Mental Health Act to bring him to a safe place where his mental health needs could be assessed.</p> <p>3 - It was reflected in evidence that whilst front line officers must receive regular refresher training on first aid, no such provision for mental health first aid training is currently being provided, on a regular and refreshing basis. There was evidence that no direct training on mental health is provided apart from initial training. Mental Health may be a topic within other qualifications and development courses as a peripheral issue of that subject, but no dedicated mental health first aid type refresher is provided at present.</p>
<b>6</b>	<p><b>ACTION SHOULD BE TAKEN</b></p> <p>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.</p>
<b>7</b>	<p><b>YOUR RESPONSE</b></p> <p>You are under a duty to respond to this report within 56 days of the date of this report, namely by May 01, 2026. I, the coroner, may extend the period.</p> <p>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.</p>
<b>8</b>	<p><b>COPIES and PUBLICATION</b></p> <p>I have sent a copy of my report to the Chief Coroner and to the following Interested Persons</p> <p></p> <p><b>Greater Manchester Mental Health</b></p> <p>I have also sent it to National Police Chiefs Council</p> <p>who may find it useful or of interest.</p> <p>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.</p> <p>I may also send a copy of your response to any person who I believe may find it useful or of interest.</p> <p>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.</p> <p>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.</p>
<b>9</b>	<p><b>Dated: 15/03/2026</b></p> <p></p> <p><b>Michael James PEMBERTON</b></p>



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**Area Coroner for  
Manchester West**

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