

## REGULATION 28: REPORT TO PREVENT FUTURE DEATHS

	<p><b>REGULATION 28 REPORT TO PREVENT FUTURE DEATHS</b></p> <p><b>THIS REPORT IS BEING SENT TO:</b> The Director of the National Probation Service</p>
1	<p><b>CORONER</b></p> <p>I am, Alison Mutch, Senior Coroner, for the coroner area of South Manchester</p>
2	<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>
3	<p><b>INVESTIGATION and INQUEST</b></p> <p>On 19/07/2017, I commenced an investigation into the death of Christopher Stewart HUTTON. The investigation concluded on the 8<sup>th</sup> January 2018 and the conclusion was one of <b>Suicide</b>. The medical cause of death was <b>1a) Hanging</b>.</p>
4	<p><b>CIRCUMSTANCES OF THE DEATH</b></p> <p>The deceased is a 48yr old single male who lives alone in a four bedroom detached property in an affluent area of Sale. In 2015 the Male was convicted for a number of offences, he is on the sex offender register and under supervision until 2021.</p> <p>On the 30th June 2017 his probation officer reported to Police that he had failed to attend a probation appointment with his supervisor on the 29/6. Officers attended the address but got no reply, they spoke to a neighbour who had a spare key and entered the house, they commenced a search and found him hanging and clearly dead in the upstairs back bedroom, he had put a butchers hook on the door and used what looked like a neck tie as a ligature his feet were a few inches from the ground, he was clothed and the indentations were consistent with the ligature used.</p>
5	<p><b><u>CORONER'S CONCERNS</u></b></p> <p>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.</p> <p>The <b>MATTERS OF CONCERN</b> are as follows. –</p> <p>(1) As part of his sentence, the deceased had been referred for an intensive Probation treatment programme. This formed a key part of the sentence. He was anxious to complete that part of the order. He had indicated that he would find it beneficial to complete the course. Despite the time that had passed since sentencing, he had not commenced the treatment plan. The reason given to the Court was that there was a high volume of demand and significant backlogs which meant that allocating places was very challenging.</p>
6	<p><b>ACTION SHOULD BE TAKEN</b></p> <p>In my opinion action should be taken to prevent future deaths and I believe you have the power to take such action.</p>
7	<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 9<sup>th</sup> March 2018. 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>
8	<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 namely [REDACTED] cousin of the deceased, who may find it useful or of interest.</p> <p>I am also under a duty to send the Chief Coroner a copy of your response.</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. 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>
9	<p><b>Alison Mutch OBE</b>  <b>HM Senior Coroner</b>  <b>12/01/2018</b></p> 