REGULATION 28: REPORT TO PREVENT FUTURE DEATHS

	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO: The Chief Constable, Greater Manchester police.**
1	**CORONER** I am John Pollard, senior coroner, for the coroner area of South Manchester
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 10th February 2015 I commenced an investigation into the death of **Ronald Arthur Laidlar** dob 3rd May 1930. The investigation concluded on the 26th June 2015 and the conclusion was one of **an Open Conclusion**. The medical cause of death was 1a Ischaemic Heart Disease due to Coronary Artery Atheroma, and Haemorrhage from scalp laceration. 11. Chronic Kidney disease
4	**CIRCUMSTANCES OF THE DEATH** **The deceased was discovered in the driveway to his house. He was naked from the waist down and he had a considerable amount of blood under and around head.**
5	**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. – 1. **The daughter of the deceased maintains that her father was wearing a wedding ring which he always wears. In the crime scene photographs, this ring is not apparent and there was no evidence to where it might be. There was no investigation as to whether it had been stolen. Local pawn shops were subsequently visited but with no success. The fact that this was missing does not seem to have been a factor in the assessment as to whether this was a crime scene.** 2. **The body was allegedly searched by detective officers and crime scene investigators at the scene. The clothing of the deceased was also similarly "thoroughly searched" and in his statement to the inquest signed on the 14th March 2015, the investigating detective sergeant states (inter alia) "the issue of the missing wallet and ring remain unresolved". In fact the wallet was found by the relatives of the deceased in the pocket of his trousers which had apparently been thoroughly searched by the police. The sergeant's evidence then changed to "there is a strong chance they were overlooked"**

3. **The sergeant initially gave evidence that the trousers of the deceased were round his ankles. When shown the crime scene photographs proving this not to be the case, he then said "in truth the trousers were at the scene with his socks and shoes". The general level of investigation of these matters fell well short of that which the public should be able to expect.**
4. **At the scene there was a lot of blood about the deceased's body and elsewhere. In answer to a question put by the coroner, the police officer confirmed that no checks had been made to test whether the blood was all from the deceased or whether there was anyone else's blood present.**
5. **The officer confirmed that they (the police) were told the deceased suffered from frequent nosebleeds and therefore assumed this accounted for the blood. The consultant pathologist confirmed there was no sign of any blood in or around the nose or mouth. There was again a lack of "curiosity" on the part of the officers.**
6. **The sergeant gave evidence that there were no marks to indicate or support third party involvement. The consultant pathologist found "a small round laceration on the right temple area measuring 0.5cm across which appeared full depth through the skin". This laceration to the scalp and the bleeding from it, was in fact one of the prime causes of death.**
7. **No fingerprints were taken at the scene.**
8. **If the level of investigation is as poor generally as it was in this case, then the possibility of crimes of violence remaining undetected remains high and therefore the chances of future deaths occurring is increased.**

6 ACTION SHOULD BE TAKEN

In my opinion action should be taken to prevent future deaths and I believe you 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 2nd September 2015. 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 namely (daughter of the deceased).

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.

9

Date 8.7.15 **John Pollard, HM Senior Coroner**