Coventry Coroners

MR S MCGOVERN
SENIOR CORONER

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REGULATION 28: REPORT TO PREVENT FUTURE DEATHS (1)

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

REGULATION 28 REPORT TO PREVENT FUTURE DEATHS

THIS REPORT IS BEING SENT TO:

Chief Constable - West Midlands Police

CORONER

1 I am S McGovern, senior coroner, for the coroner area of Coventry

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.

INVESTIGATION and INQUEST

3 On 25 April 2016 I commenced an investigation into the death of Ozeivo Andrew AKERELE. The investigation concluded at the end of the inquest on 1 November 2016. The conclusion of the inquest was a Misadventure (Copy attached).

CIRCUMSTANCES OF THE DEATH

4 See attached Record of Inquest

<u>CORONER'S CONCERNS</u>

5 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) failure to find the body of Mr Akerele despite an intensive search when in fact his body was found very close to the last confirmed sighting of him.

(2) failure to search the disused graveyard at or about the time of his disappearance. where Mr Akerele was eventually discovered 15 months later by children.- the graveyard was only a few metres away from the last sighting of him on CCTV on 31 January 2015.

(2) failure of the search team to find Mr Akerele when they did eventually search the disused graveyard in approximately late February 2015 despite the graveyard being approximately 60m x 30m.

(3) The recommendation by [redacted] for a more thorough search was not followed up.

(4)The Police Search Advisor was unaware of the recommendation for a more thorough search by [redacted]

(5) The Police Search Advisor was unaware of the (cursory) nature of the search of the graveyard in February 2015

ACTION SHOULD BE TAKEN

6 In my opinion action should be taken to prevent future deaths and I believe you as Chief Executive of the Trust have the power to take such action.

YOUR RESPONSE

7 You are under a duty to respond to this report within 56 days of the date of this report, namely by 19th July 2017. 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 Person - Mrs Akerele (mother)

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.

8 November 2016

9 **Re-dated 19 July 2017 (as previous Report appears not to have been sent)**

Senior Coroner S McGovern