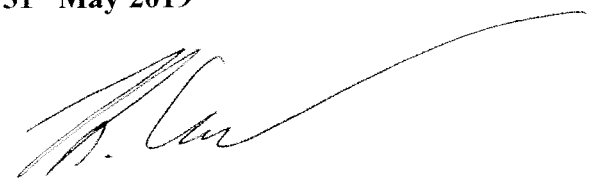
REGULATION 28: REPORT TO PREVENT FUTURE DEATHS (1)

	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS
	THIS REPORT IS BEING SENT TO: **Chief Constable Gavin Stephens – Chief Constable Surrey Police:** Office of the Police & Crime Commissioner for Surrey, PO BOX 412, Guildford, Surrey, GU3 1YJ
1.	**CORONER** I am Mrs Heidi J. Connor, Senior Coroner for the coroner area of Berkshire.
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** I conducted an Inquest into the death of Joshua Blackham which was heard at Reading Town Hall between 13th and 20th May 2019. The jury recorded their conclusion as follows: ***Medical Cause of Death:*** ***1a Asphyxia due to hanging.*** ***Narrative Conclusion*** *On the evidence heard the Jury have come to the conclusion that Joshua Oliver Maxwell Blackham, on 29th November 2016 at [redacted] did take his own life by suicide and in the opinion of the Jury the following principle [SIC] factors contributed to Joshua's death:* *1) Joshua's personal circumstances were multiple and complex in the period leading up to his death. Each of these circumstances will have placed significant stress on Joshua and in combination are likely to have contributed to his decision to end his life.*

REGULATION 28 REPORT TO PREVENT FUTURE DEATHS	
	2) The welfare system within Surrey Police at the time of Joshua's arrest was insufficient. Although a welfare officer was appointed quickly, overall governance, policy, process and training were inadequate to provide the welfare support Joshua needed. Information sharing between all stakeholders was insufficient to keep the welfare officer adequately informed and is likely to have contributed to a lack of support given to Joshua. *3) The administration, communication, controls and process in place within the NHS prior to Joshua's death failed to provide him with the mental health support he was referred for by his G.P.*
4.	**CIRCUMSTANCES OF THE DEATH** The family asked us to refer to the deceased as "Joshua" at the inquest. I have reflected that request in this report. I circulated a detailed summing up of the evidence which was circulated and agreed amongst the legal representatives for the Interested Persons in this case. <u>Brief Summary</u> Joshua Blackham was a 30 year old police officer who was arrested at work and suspended from duty on the 12th September 2016. He was allocated a Welfare Officer on the same day. A risk assessment document was sent to the Deputy Chief Constable in order for the suspension of duty to be authorised. The risk (of psychological harm) was assessed as medium by an investigating officer. This officer gave evidence that he would almost always state that the risk was "medium", for any officer suspended from duty. He never met Joshua and knew very little about his circumstances. We heard in evidence that the Welfare Officer did not receive any training to undertake this role. The only guidance provided to this officer was a document called a "specific point of contact" document which provided some limited information about what should be included in risk assessment forms. The Welfare Officer completed risk assessment forms on: a. 14th September 2016 b. 7th October 2016 c. 2nd November 2016 d. 4th November 2016 e. 4th November 2016 (an amended version)

REGULATION 28 REPORT TO PREVENT FUTURE DEATHS	
	f. 17th November 2016. Between the time of Joshua's suspension from duty and his death, the Welfare Officer met Joshua face to face twice-both times at Starbucks in Staines. A detailed chronology is set out in my agreed summary of the evidence. It is correct to say that, as time went on, the number of risk factors in Joshua's life increased. These included relationship breakdown, financial concerns and concerns about contact with his daughter. We heard that for operational reasons, the Welfare Officer did not have access to the database used by the Professional Standards Department during their investigation. Information relating to escalating concerns about Joshua was not always adequately communicated between PSD and Welfare Officer. We heard there is no central area or database for these concerns to be recorded By 28th November 2016, it became known that Joshua had previously considered and/or attempted taking his own life before, both by a previous hanging attempt in September 2016 and considering taking his own life when standing on a railway bridge. Attempts were made to contact the Welfare Officer that evening but he was off duty. There were no arrangements in place for a welfare contact in those circumstances. The Welfare Officer was not aware that, in addition, Joshua was due to be interviewed in relation to a new allegation on 29th November 2016. Tragically, Joshua was found hanged on 29th November 2016.
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 could occur unless this action is taken. In the circumstances it is my statutory duty to report to you. The **MATTERS OF CONCERN** are as follows: – It is fair to say that Surrey Police had begun work on improving policies and procedures relating to officer welfare before this inquest. There are now better policies in place regarding risk assessment, and how this should be managed. It is also noted that officers are only rarely suspended from duty whilst under investigation. There remain, however, a number of areas where there are no written policies in place in relation to the role of a Welfare Officer. I remain concerned that, given that Joshua died in 2016 and these policies are not yet in place, the impetus could be lost after the inquest.

REGULATION 28 REPORT TO PREVENT FUTURE DEATHS	
	A large number of concerns were raised during the course of this 6 day jury inquest. I have sought to focus on the areas that I consider are of key concern in this respect. These are: 1. Training – for Welfare Officers and those who supervise them. 2. It was suggested in evidence that a cadre of specialised Welfare Officers would be more effective than appointing individual officers with line management responsibilities. The advantages of this arrangement will be that the specialised skills would be held within that cadre, and that an individual officer who has been suspended from duty may feel reluctant to discuss personal matters with a senior officer in his/her own management line. I consider this suggestion should be considered by Surrey Police. 3. Consideration should be given as to how communication of concerns between PSD and the Welfare Officer can take place more effectively. 4. Consideration should be given to the Welfare Officer contacting the family of the officer suspended from duty, to gain further information, where appropriate consent has been given. 5. Any new arrangement should make allowances for contact with a Welfare Officer where the primary Welfare Officer is off duty. 6. There should be a written policy as to the location of the arrest of a serving officer, so as to reduce the impact of this on his/her welfare.
6.	**ACTION SHOULD BE TAKEN** In my opinion urgent action should be taken to prevent future deaths and I believe your organisation has 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 26th July 2019. 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.

REGULATION 28 REPORT TO PREVENT FUTURE DEATHS	
8.	**COPIES and PUBLICATION** I have sent a copy of my report to the Chief Coroner and to Joshua's legal representative. 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.	**31st May 2019**  **Mrs Heidi J. Connor** **Senior Coroner for Berkshire**