Regulation 28: Prevention of Future Deaths report

Agnès Blandine Marthe MARCHESSOU (died 14.07.20)

	THIS REPORT IS BEING SENT TO: **1. Commissioner [redacted]** **Metropolitan Police Service (MPS)** **6th Floor, New Scotland Yard** **Victoria Embankment** **London SW1A 2JL**
1	**CORONER** I am: Coroner ME Hassell Senior Coroner Inner North London St Pancras Coroner's Court Camley Street London N1C 4PP
2	**CORONER'S LEGAL POWERS** I make this report under the Coroners and Justice Act 2009, paragraph 7, Schedule 5, and The Coroners (Investigations) Regulations 2013, regulations 28 and 29.
3	**INVESTIGATION and INQUEST** On 29 July 2020, I commenced an investigation into the death of Agnès Blandine Marthe Marchessou. The investigation concluded at the end of the inquest on 25 November 2020. I made a narrative determination, which I attach.
4	**CIRCUMSTANCES OF THE DEATH** Agnès Marchessou [redacted]. She had suffered fragile mental health for the four or five years leading up to her death. On 4 July 2020, she was arrested for assault following a domestic incident. On 8 July 2020, she was knocked over by a bus. Police and ambulance services attended and she was conveyed to hospital.

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.

Metropolitan Police Service officers attended Ms Marchessou on 8 July 2020, after she had been knocked over by the bus.

1. One of the police officers interviewed the bus driver, who told him that Ms Marchessou had stopped when the bus driver sounded his horn, but then had stepped straight in front of the bus, and after she had been hit had got up and run in front of another bus, only being saved when a passer-by grabbed hold of her.

   The police officer did not pass on this crucial account to the emergency ambulance crew who transported Ms Marchessou to hospital, nor to any of the doctors or nurses at the hospital.

2. Ms Marchessou told the police officers that she had blacked out and could not remember what had happened, then that she thought she had stepped into the road as the result of a panic attack. She also said that she had stepped in front of the bus because she was upset about being denied contact with her children.

   The police officers did not pass on the crucial information that Ms Marchessou said she had stepped in front of the bus because she was upset about being denied contact with her children, either to the emergency ambulance crew or to the treating doctors or nurses.

3. The two police officers waited with Ms Marchessou at the hospital for well over two hours, but did not at any point during that time radio police control to ask for any enquiries or searches of police systems to be made.

   Such information could have been potentially extremely helpful to those treating Ms Marchessou.

4. When the police officers returned to the police station, they did make a search themselves and discovered that she had been arrested for domestic violence. However, they did not make a Merlin record of her potential vulnerability and need for assistance.

	5. I was provided with a statement from one of the two police officers in advance of the inquest and I called him to give oral evidence on 25 November 2020. When I put to him the sub optimal nature of the way that he had dealt with the incident on 8 July 2020, he did not appear to have undertaken any reflection on this in the intervening four and a half months, nor in the witness box. If there was any error in not passing on information, he attributed this error to his colleague. He did not consider that he had failed to apply a healthy degree of scepticism to Ms Marchessou's version of events, particularly in the light of the bus driver's description. He reiterated the view he had formed on the day, that Agnès Marchessou being hit by a bus was purely an accident. The police officer defended all of his actions robustly. I could not see that he had learnt anything as a result of these events or that anything about his practice would change in the future. 6. The police officer giving evidence was aware of the view of the Directorate of Professional Standards (DPS) regarding the failure to create a Merlin, expressed in its report on the police handling of the incident on 8 July, but he seemed very confused about how that should work in practice. If he is confused, even after police have taken him through the DPS report, then other police officers may also be confused.
6	**ACTION SHOULD BE TAKEN** In my opinion, action should be taken to prevent future deaths and I believe that 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 25 January 2021. 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 following.

	• HHJ Mark Lucraft QC, the Chief Coroner of England & Wales • MPS Directorate of Professional Standards • PC [redacted] • PC [redacted] • Dr [redacted], Whittington Hospital Emergency Unit • Mr [redacted], husband of Agnès Marchessou • Mme [redacted], mother of Agnès Marchessou 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. I may also send a copy of your response to any other person who I believe may find it useful or of interest. 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.
9	**DATE** **SIGNED BY SENIOR CORONER** 27.11.20 *ME Hassell*