Regulation 28: Prevention of Future Deaths report

Joseph MARTIN (died 07.06.21)

	THIS REPORT IS BEING SENT TO: **1. Chief Constable [redacted]** **Chief Constable of the Police Service of Northern Ireland** **Belfast**
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 10 June 2021, one of my assistant coroners, Jonathan Stevens, commenced an investigation into the death of Joseph Martin aged 43 years. The investigation concluded at the end of the inquest earlier today. The determination made at inquest was as follows. Joseph Martin died from [redacted]. The exact circumstances of him [redacted] are unclear, but there is no evidence of any other person being involved, and he was suffering a psychotic relapse at the time. The medical cause of his death was: [redacted]
4	**CIRCUMSTANCES OF THE DEATH**

	Joseph Martin had approached Metropolitan Police Service (MPS) officers near Westminster Bridge on 3 June 2021. The considered his mental welfare and contacted the police force local to where he lived, the Police Service of Northern Ireland (PSNI). However, the MPS were not given full details of the concerns about his mental health raised with the PSNI by his family, friends and mental health team, so the officers had no power to detain him under section 136 of the Mental Health Act. They walked him to the nearest hospital, but he did not enter it.
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. Joseph Martin was reported as a person of concern to the PSNI on 28 May 2021 by staff at the hostel where he lived. His consultant psychiatrist called the PSNI on 1 June 2021 and raised very grave concerns about what he described as a vulnerable missing person, explaining that Mr Martin had suffered a psychotic relapse, and voicing significant worries about his safety and about the safety of others. The doctor re-iterated and reinforced all of this on 2 June, when the PSNI rang him to say that they did not consider any further action required. He was told that it would be looked into further. However, when the MPS contacted the PSNI on the morning of 3 June, these concerns were not relayed. I was told that the contacts had not been noted on the missing person report or the occurrence log by the investigating officer. Then the officer tasked with calling the MPS back did not conduct a search of all records, and so did not see the contacts. Finally, when a PSNI officer rang Mr Martin's mother to say that her son had approached MPS officers, and she told the officer how very worried she was about her son's mental health, the officer did not then call the MPS back. I appreciate that by then he thought that Mr Martin was going to go to hospital, but Mr Martin had not been detained and in any event the hospital needed the crucial medical history that had been given. There were individual errors, and more significantly a system that does not seem to have provided a safety net.

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** I should be grateful for your response to this report within 56 days, namely by 10 January 2021. Do contact me if you would like to extend the period. Kindly include details in your response of action taken or proposed to be taken, setting out the timetable for action, or explain why no action is proposed.
8	**COPIES and PUBLICATION** I have sent a copy of my report to the following. • [redacted], mother of Joseph Martin • [redacted], uncle of Joseph Martin • Dr [redacted], psychiatrist, St Luke's Hospital, Armagh • [redacted], manager, Simon Community, Armagh • Constable [redacted], PSNI • HHJ Thomas Teague QC, the Chief Coroner of England & Wales I am also under a duty to send a copy of your response to the Chief Coroner of England & Wales 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** 16.11.21 *ME Hassell*