## **Regulation 28: Prevention of Future Deaths report**

Michael ROBERTS (died 20.08.22)

	THIS REPORT IS BEING SENT TO:		
	1.	Chief Executive Disclosure and Barring Service (DBS) PO Box 3961 Royal Wootton Bassett SN4 4HF	
	2.	Commissioner Metropolitan Police Service (MPS) New Scotland Yard Victoria Embankment London SW1A 2JF	
1	CORONER		
	I am:	Coroner ME Hassell Senior Coroner Inner North London St Pancras Coroner's Court Camley Street London N1C 4PP	
2	CORC	ONER'S LEGAL POWERS	
	parag The C	e this report under the Coroners and Justice Act 2009, raph 7, Schedule 5, and oroners (Investigations) Regulations 2013, tions 28 and 29.	
3	INVESTIGATION and INQUEST		
	On 30 August 2022, one of my assistant coroners, Jonathan Stevens, commenced an investigation into the death of Michael Roberts aged 50 years. The investigation concluded at the end of the inquest on 7 February 2023. I made a determination at inquest of suicide.		
4	CIRC	JMSTANCES OF THE DEATH	

	Mr Roberts shot himself on the evening of Saturday, 20 August 2022, using a gun he took from his place of work. He did not own any guns.		
	He was alone and made no attempt to shoot any other person. However, he had suggested to his partner that he could kill her.		
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.		
	Before he was employed as a proof assistant testing new guns, Mr Roberts' prospective employer asked for a DBS (Disclosure and Barring Service) certificate. This was provided and recorded no convictions, cautions, reprimands or warnings.		
	However, Mr Roberts had in the past been convicted of a violent offence for which he had received a custodial sentence. This was the reason for his dismissal from his former occupation as a police officer in the MPS (Metropolitan Police Service).		
	If Mr Roberts' DBS certificate had correctly recorded his conviction, he would not have been employed at Proof House where he had access to firearms.		
	It is unclear to me whether the inaccuracy of the DBS certificate was caused by an error made by the DBS or by the MPS.		
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 10 April 2023. 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.			
	<ul> <li>wife of Michael Roberts</li> <li>mining and the second s</li></ul>			
	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 CORO	NER		
	13.02.23 ME Hassell			