REGULATION 28: REPORT TO PREVENT FUTURE DEATHS (1)

[redacted]

	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO:** **1. [redacted], Chief Executive, College of Policing, 58 Leamington Road, Ryton-on-Dunsmore, Coventry, CV8 3EN**
1	**CORONER** I am Andrew Cox, Acting Senior Coroner for the coroner area of Cornwall and the Isles of Scilly.
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** On 3 May 2018, an inquest was opened into the death of [redacted] who died on 30 April 2018. The inquest culminated in a final hearing on 20 November 2019 with a conclusion being recorded of suicide. The cause of death identified at post-mortem was: 1A) hanging
4	**CIRCUMSTANCES OF THE DEATH** On 4 April 2018, [redacted] was interviewed by Devon and Cornwall police in relation to allegations [redacted]. He denied all the allegations. On 18 April 2018, [redacted] reported her husband as a missing person. She also received a text message from him indicating that she would be "better off without him." On 19 April 2018, [redacted] was detained by police under section 136 of the Mental Health Act and taken to a place of safety. A Mental Health Act examination was conducted following which [redacted] was discharged with advice to contact his GP. On 29 April 2018, at approximately 10:00 AM, [redacted] told his wife that he was going to a local supermarket to buy milk. He did not return. At 18:00 hours, [redacted] reported to police that her husband was missing. An initial risk assessment assessed the level of risk at medium. Sergeant (now Inspector) [redacted] came on duty at 21:30 hours. His initial review of the log caused him to

	express concern that the appropriate level of risk was high. He asked for a review from the duty Inspector, Inspector [redacted] A review was conducted shortly thereafter, and the level of risk was maintained at medium. A number of additional enquiries, however, were put in train, for example, tasking an officer check whether there was milk at the [redacted] property and, additionally, insisting upon review of CCTV footage at the local supermarket. The latter enquiry revealed that [redacted] had not been to the supermarket but instead had misled his wife. At approximately 02:00 hours on 30 April, the level of risk was re-assessed as high. A helicopter was tasked to look for [redacted] (and another missing person) and attempts were made to triangulate his position using his phone. [redacted] was subsequently found hanged in a secluded area of woodland later that morning.
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. The appropriateness of the police response to the report of [redacted] as a missing person on 29 April was considered by the IOPC. In evidence at the inquest, I heard from their [redacted] who concluded that there had been an opportunity to raise the risk to high at an earlier stage. He did note, however, that the matter had ostensibly been dealt with as a high-risk response for some time prior to its re-categorisation at that level. I was not able to conclude that the delay in raising the level of risk to high had been causative of the death as it was not known at what time [redacted] had, in fact, hanged himself. It had to be noted that there was a period of approximately eight hours before he was first reported to police as a missing person. It was accepted in evidence that the decision as to the appropriate level of risk was essentially a "judgement call" on the part of the individual officer. It was further accepted that there would be occasions when these judgements would be very finely balanced. It was not felt that there had been any failure to follow practice or protocol at a local level. It was noted, however, that it would be sensible to share the salient facts with you in order that there could be a proper review of the guidance contained within the relevant College of Policing APP upon which the police officers relied. It was recognised that if the guidance could be clearer this may assist different officers from achieving a greater level of consistency in decision-making when faced with the same, complex set of facts.

6	**ACTION SHOULD BE TAKEN** In my opinion action should be taken to prevent future deaths and I believe you [AND/OR your organisation] have the power to take such action. Would you please consider whether it would be appropriate to review the Missing Person APP MP101 in the light of the facts set out above. If so, would you please let me know whether or not you feel it appropriate to issue amended guidance.
7	**YOUR RESPONSE** You are under a duty to respond to this report within 56 days of the date of this report, namely by 21/01/2020. 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 Chief Coroner and to the following Interested Persons: the family, the Chief Constable of Devon and Cornwall Constabulary, the IOPC and Cornwall Partnership Foundation Trust. 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	**[DATE]** **22/11/2019** **[SIGNED BY CORONER]**