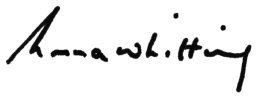
Regulation 28: REPORT TO PREVENT FUTURE DEATHS

NOTE: This form is to be used **after** an inquest.

	REGULATION 28 REPORT TO PREVENT DEATHS **THIS REPORT IS BEING SENT TO:** **1 Commissioner** [redacted]
1	**CORONER** I am Emma WHITTING, Senior Coroner for the coroner area of Bedfordshire and Luton Coroner Service
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 12 October 2022 I commenced an investigation into the death of Nicola FORSTER aged 45. The investigation concluded at the end of the Inquest on 03 June 2024. The **Conclusion of the Inquest** was that: **The Deceased intentionally took her own life following a deterioration in her mental health which was exacerbated by the actions of her employer.**
4	**CIRCUMSTANCES OF THE DEATH** The Deceased, a serving Metropolitan Police Service (MPS) Sergeant, had worked for the MPS for over twenty-two and a half years mostly as a front-line officer; in early 2020, she had joined the Learning and Development Team at Hendon as a Public & Personal Safety Instructor Sergeant, which was a job she loved. She had struggled with mental and physical health issues for several years, including work-related PTSD, but had found counselling helpful for dealing with this. Her mental health declined from autumn 2021 when she found herself under increasing pressure at work and lost access to counselling. An Occupational Health Referral was discussed with her line manager but was not progressed until 23 May 2022 when, because her health had impacted on her ability to lead and supervise her Team, she was also issued with informal management action. Although she was always open about her mental health issues, line management decisions made in respect of her reflected a focus on managing upwards and were supported by the Senior Leadership Team; these decisions were at the expense of the Deceased's personal and occupational welfare and contributed to a further significant deterioration in her mental health. Despite the intervention of the Deceased's local mental health Crisis Team, who provided her with out-patient care from 21 September 2022, on the morning of 28 September 2022, she was found hanging by a ligature made from her dressing gown belt attached to the landing banisters at her home. Emergency Services attended but her death was confirmed by paramedics at 10.56 hours. She had last been heard from at around 01.00 hours that morning when she had sent a text message to her partner saying that her sleeping medication was not working.
5	**CORONER'S CONCERNS** During the course of the investigation my inquiries revealed matters giving rise to concern. In my opinion there is a risk that future deaths could occur unless action is taken. In the circumstances it is my statutory duty to report to you.

	The **MATTERS OF CONCERN** are as follows: (brief summary of matters of concern) Although I was informed during the Inquest process about various changes that have been made to MPS Employment Policy and Processes since Nikki's death, including the introduction of a new 'Raising Concerns' Policy in May 2023, I believe there remains evidence of a culture of poor management and institutional defensiveness, as highlighted in the Baroness Casey Review, which these changes do not address. There is no point in encouraging concerns to be raised whilst this culture persists. My investiation into Nikki's death revealed clear evidence of officers, particularly the more junior ranking officers, having a fear of speaking out about their management and also an unwillingness, by the L&D Senior Management Team, to listen independently to the concerns raised. Furthermore the PSU (as well as the DPS investigation after Nikki's death and your representation at the Inquest) appeared only to seek to support the role of senior management; even though the Inquest found that aspects of Nikki's management had been seriously deficient and had contributed to her death. This appeared to me to confirm the criticism made by Baroness Casey that the MPS "*starts from a position that nothing wrong has occurred*" and their "*systems support wrongdoers*".
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.
7	**YOUR RESPONSE** You are under a duty to respond to this report within 56 days of the date of this report, namely by August 15, 2024. 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 [redacted] [redacted] [redacted] [redacted] **(Associate Legal Director ELFT)** I have also sent it to **Mayor of London** who may find it useful or of interest. 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 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 by the Chief Coroner.
9	**Dated: 20/06/2024**  **Emma WHITTING** **Senior Coroner for** **Bedfordshire and Luton Coroner Service**