REGULATION 28: REPORT TO PREVENT FUTURE DEATHS

	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO:** [redacted], Commissioner of the Police of the Metropolis. (via email to his legal representative) [redacted], Chief Executive Officer of the College of Policing (via [redacted])
1	**CORONER** I am Professor Fiona J Wilcox, HM Senior Coroner, for the Coroner Area of Inner West London
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** From 3rd March to 24th March 2025, evidence was heard before a jury touching the death of Mr Oladeji Adeyemi Omishore. He had died on the 4th June 2022, aged 41 years, in ITU at St Thomas's Hospital. He had died following an incident involving police officers on Chelsea Bridge during which he was tasered a number of times and then jumped into the River Thames. **Medical Cause of Death** 1 a. Complications arising from drowning **How, when, where and in what circumstances the deceased came by his death; and conclusions as recorded by the jury [in this case by combining boxes 3 and 4 of the Record of Inquest] :** *on 4th June 2022, Mr Omishore was suffering with a relapse of schizoaffective disorder/psychosis. In October 2019 he had suffered his first episode of schizoaffective disorder/psychosis based on medical evidence we have heard and accepted. He continued to receive care and deemed stable by the health care team in March 2022. Recent cannabis use likely caused or contributed to this relapse of his illness. We have considered and noted his previous behaviour when psychiatrically unwell.* *Mr Omishore left his home on the morning of 4th June 2022 shouting in the middle of the road and waving what is now known to be a firelighter. This prompted a number of 999 calls from members of the public. Amongst other things, the public raised shouting religious remarks, a perceived weapon, aggressive behaviour and that he seemed mentally unwell.*

The call handlers determined critical information and passed to dispatchers which included location, weapon and description, with all calls being graded I grade (immediate response). Responding police officers were told by dispatchers the location, suspicious circumstances, weapons and a brief description via the airwaves. Mental health (MH) was not passed over the airwaves. We note from witnesses this should and could have been passed over the airwaves.
The call was accepted by the responding officers at 09:03:54. It was accepted 20 seconds after it was put over the airwaves.
The response officers understood they were responding to an I grade call on Chelsea Bridge Road, which they were aware had at least 3 I grades.
When the response officers arrived, Mr Omishore was in the middle of the road on the North side of Chelsea Bridge when the officers first saw him. The officers perceived him to be holding a screwdriver.
The taser trained officer gave evidence to say he did not initially consider possible MH issues. The non-taser trained officer gave evidence he did consider MH issues during the incident. The response officers gave evidence that they believed this was a genuine threat and took a risk assessment in line with NDM.
The response officers arrived at 09:05:43 and the taser officer got out the car with taser drawn and shouted commands to identify himself as a police officer and to draw attention to the taser. Following lack of compliance to drop the object, the taser officer fired the first taser at 09:06:15, in response to non-compliance and movement in the direction of the ono-taser officer. Mr Omishore dropped to the ground and dropped the object. Following the first taser, Mr Omishore was rolling around on the ground and was not under control. The non-taser officer kicked the object away from reach. Mr Omishore attempted to get up and swiped towards the non taser officer and there was a second discharge. The second taser did not allow control of Mr Omishore. Following the third taser discharge, Mr Omishore got up and jumped over the pedestrian barrier. The non-taser officer followed.
Mr Omishore swung his hand towards the non-taser officer and knocked the handcuffs out of his hand.
The taser officer deployed the second and final cartridge to stop Mr Omishore. Mr Omishore jumped off Chelsea Bridge and into the River Thames at 09:06:53-55.
He was rescued at 09:18 and was given CPR and taken to St Thomas's Hospital.
He was recognised as life extinct on ITU at St Thomas's Hospital at 20:29 on 4th June 2022.

<u>Matters that we find possibly caused or contributed to the death.</u>

Despite the response officers having all required training, the use of the taser did not achieve full NMI. Had the officers been able to achieve full NMI, there is a possibility they could have gained control of Mr Omishore and therefore the inability to achieve full NMI and gain control of Mr Omishore possibly contributed to his death.

Information from members of the public (that in their opinion Mr Omishore was suffering from a mental health crisis) was not passed to responding officers before they arrived at the scene.
We have heard evidence that such information should and could have been passed on. We have also heard evidence from the responding officers that such information would not have changed their approach.

The majority of the jury find that, had mental health concerns been passed over the airwaves, it is possible this may have had an impact on the sequence of events that may have contributed to Mr Omishore's death.

<u>Probable Causes</u>

Mr Omishore had suffered a relapse of schizoaffective disorder/psychosis and was severely unwell. This illness affected his understanding and was the likely cause of his actions on Chelsea Bridge Road and Chelsea Bridge prior to and after the arrival of the

	police. It is likely that he was frightened by what he was seeing and what he thought he was seeing and lacked insight. *Whilst the body worn and phone footage show him running away from police after he had been tasered for the third time, it cannot be concluded that the actions of the police probably caused his death.*
4	**Evidence relevant to the matters of concern.** Extensive evidence was taken and exhibited and some potential regulation 28 matters explored. Please see the detailed findings of the jury laid out above. Of relevance to this report: 1. Mr Omishore had been observed by multiple members of the public on Chelsea Bridge Road and then on Chelsea Bridge, in the minutes leading up to the incident behaving in a manner that suggested he was mentally unwell. There were 7 calls by members of the public to the Metropolitan Police to report concerns and in 3 out of 7 of these calls the member of the public told the call handlers/first responders that Mr Omishore appeared mentally unwell. This was only recorded by one call handler on the CHS system and passed to the CAD and thus dispatchers in "remarks." This information was never transmitted over the airwaves to the responding officers and so could not have been considered in their NDMs prior to their arrival at the scene. The responding officers had no access to CADs to undertake their own assessment prior to arriving at the incident due to a combination of lack of time to start their computer tablet and to load and search CADs due to the immediacy of their arrival and the IVMA was not working. They were thus reliant on the information passed to them over the radio. Only one radio channel was used in this incident. 2. Extensive evidence was taken in relation to this matter. In summary: call handlers stated that given the main threat was that Mr Omishore had been reported as carrying a weapon, either knife or screwdriver, they regarded mental health as a secondary matter and did not put the information in the "golden line", and indeed two did not record it all. Neither was the information recorded in the NICL codes. The main reasons given for this was that in their views, the NICL codes should list the main risk factors, only three are available and if a mental health NICL code was recorded then it would need a further code qualifying it as "believed" as the information was unconfirmed as reported by a member of the public rather than a health care professional, or relative with first-hand knowledge of the subject. There was also mention of the officers' duties to consider such matters once they have arrived at the scene of an incident. 3. Several witnesses stated that a code "mental health believed" would be of assistance as then there would likely have been enough NICL codes available for it to be used. There was some inconsistency therefore between whether it should be recorded at all, and if so where it should have been recorded. 4. To be clear it was accepted in the evidence that mental health should have been recorded and passed out over the airwaves to responding officers as it would have assisted those officers in their NDM considerations.

	5. The evidence from dispatchers based at AWS, was that the information in relation to possible mental health matters should have been recorded and passed to them to put out. It was clear from the evidence that the information that was passed to dispatchers was not put out in error- it was simply missed. 6. These dispatchers described how they relied on information in the "golden line" and NICL codes to get information out onto the radio asap, and so it could be inferred that had information in relation to mental health issues been recorded either in the "golden line" or NICL codes it would have been likely to have been transmitted by them. 7. Analysis of various CADs as part of the evidence also showed that several units (up to 6, it was difficult to understand) had been allocated to respond to this incident in addition to three units heard to respond over the airwave radio. None of this potentially important information was passed over the airwaves, and again therefore could not have been considered by responding officers and thus feed into their NDMs. 8. The incident was being monitored in dispatch AWS by a controller performing multiple tasks who had also missed the remarks in relation to mental health and not passed on information over the airwaves in relation to units assigned by CAD from another geographic dispatch pod (AWC) over the airwave radio. 9. Evidence was also taken in relation to the increased use of taser in black men and those persons with mental health needs and the training given to staff and officers in relation to these matters. 10. Evidence was taken in relation to THRIVE . 11. In relation to the response of the officers, the taser armed officer deployed with his taser drawn and pointed at Mr Omishore and did not consider mental health as a possible cause for Mr Omishore's actions until after the first use of the taser. However, had he been provided with information that Mr Omishore appeared to be suffered with mental ill health prior to his arrival at the scene, this could have fed into his NDM and may have affected the manner of his deployment. This may have reduced the risk of escalation arsing not only from sight of the taser but also the training requirement to use clear and commanding language to a subject once a taser has been deployed. Such language is different in tone and style to that taught to officers to use when attempting to de-escalate a situation where the subject is suffering mental distress. These matters could not be found to have likely affected the outcome in this case.
5	**Matters of Concern** 1. That there is an inconsistancy of approach between call handlers/first responders in the recording of information passed to them by members of the public that may represent a training issue; in this case the mental health matters reported to them.

2. That the call handlers/ first responders may have a training issue in relation to the importance of recording this information in manner which is likely to be passed on to responding officers by dispatchers, for example in the NICL codes and/ or “golden line”.

3. That the above concern of potential training need is highlighted by the increased use of taser in black men and those suffering mental health issues and so the real need for this information to be recorded and passed on in the most effective form. Whilst training for first responders appears to include advice as how to communicate with persons suffering with mental health issues, it does not appear to contain any advice in relation to the importance of such information to be recorded especially in relation to black men.

4. That the limitation of 3 NICL codes makes it difficult to record mental health as a qualifier in incidents such as this where the main risk factor is the weapon.

5. That call handlers/first responders may need training as to where to record such information i.e. in the “golden line” or NCIL code, as long as of course it is reported to them before the “golden line” and NICL code has gone out.

6. That use of THRIVE usually requires time that is not available in I grade calls and does not mitigate the need to circulate promptly information as to mental health issues, in the format most likely to digested and passed on by dispatchers that is “golden line” or NICL codes.

7. That the lack of NICL code “mental health believed” compounds this.

8. That dispatchers may require training in relation to the importance of passing on possible mental health concerns for the subject over the airwaves given the increased use of taser in black men and those suffering with mental ill health.

9. That dispatchers may require training in relation to what to pass out more generally given the confusion in the evidence about other units being assigned by CAD, which dispatchers themselves did not seen to appreciate and understand let alone pass such information out to responding officers.

10. That there are apparent system failure issues in dispatcher pods if due to pressure of work, important issues such as mental health concerns for the subject are being missed and the number of units on the way are not being passed over the airwaves, given the potential importance of these matters to responding officers when applying their NDMs, and the reliance of responding officers on the information that they receive over the radio on their way to an I grade call.

11. That training for response officers may require review in relation to tactical options used to de-escalate prior to taser deployment, in appropriate circumstances, given the increased use of taser in black men with mental health issues; and in particular, training in relation to deploying with taser

	drawn and pointed with accompanying commanding language where the subject may be suffering with mental ill-health.
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. It is for each addressee to respond to matters relevant to them.
7	**YOUR RESPONSE** You are under a duty to respond to this report within 56 days of the date of this report. 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: Parents of Oladeji Adeyemi Omishore (via their legal representatives) Officers [redacted] and [redacted] (via their legal representatives) 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	**25th March 2025**  **Professor Fiona J Wilcox** **HM Senior Coroner Inner West London** **Westminster Coroner's Court** **65, Horseferry Road** **London** **SW1P 2ED** **Inner West London Coroner's Court,** **33, Tachbrook Street,** **London.** **SW1V 2JR** **Telephone:0207 641 8789.**