REGULATION 28: REPORT TO PREVENT FUTURE DEATHS

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

	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO:** Chief Constable, Thames Valley Police
1	**CORONER** I am Nicholas Graham, HM Area Coroner for Oxfordshire, c/o Oxfordshire Coroner's Office, 1 Tidmarsh Lane, Oxford OX1 1NS
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 January 2024**, I commenced an investigation into the death of **Katherine Wright, known as Sarah, aged 60**. The investigation concluded at the end of the inquest on **4 December 2025**. The conclusion of the inquest was a **Narrative Conclusion**: Sarah Wright was found deceased at her home address on 20 December 2023. She had a long-standing history of chronic alcohol misuse. Concerns for her welfare were raised on 15 December 2023 and police attended her address on 16 December 2023 but did not locate her. She was subsequently found deceased on 20 December 2023 following a further search of her address. Post-mortem examination and toxicological tests revealed no traumatic injuries or natural causes for her death, but tests did confirm significant alcohol levels. Her death was likely caused by sudden unexpected death in the context of alcohol misuse. It has not been possible to determine on the evidence when Sarah died and whether, if she had been found earlier, she would have survived.
4	**CIRCUMSTANCES OF THE DEATH** Sarah Wright was reported missing on 15 December 2023. Thames Valley Police officers attended her flat on 16 December 2023, forced entry, and conducted a search but did not locate her. She was later found deceased in the same flat on 20 December 2023, during a second search. The Professional Standards investigation and evidence at the inquest confirmed that the initial search was inadequate. The officer who undertook the bedroom search cited concerns about personal safety due to the cluttered

	condition of the room but did not escalate these concerns. The family were informed that a thorough search had been completed.
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 could occur unless action is taken. The **matters of concern** are as follows: 1. **Lack of training and guidance for frontline officers on conducting searches of premises in missing person cases.** Evidence given by the Police at the Inquest indicated that there is no structured training or clear operational guidance on what constitutes an adequate search, including checking all areas of a property where a person could reasonably be found. 2. **Absence of protocols for escalating safety concerns during searches.** The officer who undertook the search felt unsafe due to the cluttered environment but did not escalate this concern or request additional resources to enable an adequate search to be carried out. There appears to be no guidance on when and how officers should escalate such issues.
6	**ACTION SHOULD BE TAKEN** In my opinion action should be taken to prevent future deaths and I believe your organisation has 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 5th February 2026. 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: • Sarah Wright's family 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	**09 December 2025**  Mr Nicholas Graham, Area Coroner for Oxfordshire