Regulation 28: Prevention of Future Deaths report

Jeroen ENSINK (died 29.12.15)

	THIS REPORT IS BEING SENT TO: **1. Deputy Assistant Commissioner Richard Martin** **Metropolitan Police Service** **6th Floor, New Scotland Yard** **Victoria Embankment** **London SW1A 2JL**
1	**CORONER** I am: Coroner ME Hassell Senior Coroner Inner North London St Pancras Coroner's Court Camley Street London N1C 4PP
2	**CORONER'S LEGAL POWERS** I make this report under the Coroners and Justice Act 2009, paragraph 7, Schedule 5, and The Coroners (Investigations) Regulations 2013, regulations 28 and 29.
3	**INVESTIGATION and INQUEST** On 30 December 2015, one of my assistant coroners, Jacqueline Devonish, commenced an investigation into the death of Jeroen Ensink, aged 41 years. The investigation concluded at the end of the inquest on 17 July 2018. The jury made a narrative determination, which I attach.
4	**CIRCUMSTANCES OF THE DEATH** Dr Ensink was stabbed to death in a wholly unprovoked attack. Following a guilty plea, [redacted] [redacted] was convicted of manslaughter by way of diminished responsibility, and a hospital order was made. [redacted] was diagnosed with paranoid schizophrenia.

[redacted] had been arrested seven months earlier for possession of a bladed article and assault on a police constable. He was granted police bail and given a long bail date because he intended to return to Nigeria.

However, he stayed in Nigeria longer than anticipated and so failed to answer his bail on 25 August 2015. Instead, his sister attended Holborn Police Station with a letter from his doctor in Nigeria describing mental ill health including paranoia and hallucinations.

He was arrested at Heathrow upon his return to the UK on 11 October 2015, and was granted bail by Highbury Coroner Magistrates, with conditions including surrendering his passport and reporting to a police station every day.

The CPS (Crown Prosecution Service) later made a decision to discontinue the prosecution, a decision that they reviewed after Dr Ensink's death and considered was wrong.

However, if the right decision had been made, at that point the only material difference would have been that [redacted] would have had to continue reporting to a police station each morning after 23 December 2015 (his last reporting day) and until the trial on 5 January 2016.

In the event, Dr Ensink was stabbed on 29 December 2015.

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.

1. Following his arrest on 22 May 2015, no officer created a Merlin in respect of [redacted], though his behaviour suggested to both arresting officers the possibility that he was suffering mental health or substance abuse problems. Thus the MASH (multi agency safeguarding hub) was never alerted to his potential need for treatment.

2. Police officers at the scene of [redacted] arrest took a statement in support of the prosecution of the offence of possession of a bladed article in a public place. However, they missed out a line from the statement that the CPS considered was vital to demonstrating [redacted] location when he had the knife. This omission was rectified only months later.

3. Only one statement was taken, though there were other witnesses on scene.

4. The custody sergeant who booked [redacted] into custody recorded that [redacted] had threatened police officers with a knife, though there was no mention of this on the CRIS (crime record information system) report or in the officers' statements, and both officers gave evidence at inquest that [redacted] had not had a bladed article in his possession when they arrested him. This was later found on the windowsill through which he had climbed into the property.

5. The custody sergeant noted that [redacted] had a bruised, bleeding and swollen lip, yet to the custody record question regarding any injuries, he recorded no.

6. The arresting officers described in evidence a violent struggle with [redacted] when they arrested him. He had tried to grab the Taser belonging to one of the officers. Yet the custody sergeant recorded that no force had been used. And this was despite the fact he said that he was under the impression that [redacted] had wielded a knife against the officers. He said in evidence this was because the force had been used outside the police station.

7. Both arresting officers formed the view that [redacted] was suffering mental health or substance abuse problems, and both included these two factors in their statements, but the custody sergeant gave evidence that no mental health concerns were brought to his attention.

8. Consequently, no mental health concerns were brought to the attention of the FME (forensic medical examiner) who examined [redacted], meaning that his mental state examination was more superficial than it would otherwise have been.

9. Both arresting officers thought there was a possibility that [redacted] was under the influence of cannabis. The custody sergeant recorded this as heavy cannabis use, he said because in his experience people who use cannabis use it heavily.

10. The custody sergeant gave evidence that, had it not been for suspected cannabis use, he would not have called the FME for any other reason.

11. When [redacted] sister rang the police station to explain that in Nigeria, her brother had been diagnosed with mental health problems, and to ask that she be permitted to attend during his interview as an appropriate adult, the detention officer recorded this, but the system did not create any sort of alert or pop up.

12. Neither custody sergeant working that night read the note of the conversation recorded by the detention officer in the detention log.

13. Consequently, the FME was never alerted to this, and so did not return to re-examine [redacted].

14. The booking in custody sergeant recorded authorisation of a strip search, but did not record the result of the search.

15. The interviewing officer did not read the CRIS report, and gave evidence that it was not MPS protocol so to do. The CRIS report contained a record of the question mark over [redacted] mental health.

16. The interviewing officer was surprised when [redacted] denied possession of a bladed article in a public place but volunteered possession of a hammer. As a consequence of his surprise, he asked very few questions about this and did not pursue it.

17. The PNC (police national computer) was never flagged with a warning that [redacted] had mental health problems, either after his arrest, after his sister's phone call, or after the letter from his Nigerian doctor was presented and scanned onto COPA (case overview and prosecutions application); and was never flagged with a warning that he had assaulted a police officer.

18. There was no common understanding among police officers of who should look where, when, for what: the PNC, the Merlins, the CRIS, the COPA, the detention log, the custody record risk assessments etc.

19. There was an almost total lack of understanding among police officers of the detail of the CPS Notice of Proposed Discontinuance procedure, most particularly in terms of who this should go to, who should send it, what actions are then possible and what impact these actions might have.

It did not seem to me that there was one defining moment in the months leading up to Dr Ensink's death, but rather there were many apparently inconsequential moments. Errors or omissions may seem small at the time, but each – both individually and cumulatively – represents a missed opportunity that has the potential for devastating consequences.

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 17 September 2018. 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. • HHJ Mark Lucraft QC, the Chief Coroner of England & Wales • Ms Alison Saunders, Director of Public Prosecutions • [redacted], wife of Jeroen Ensink 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 Senior Coroner, at the time of your response, about the release or the publication of your response by the Chief Coroner.
9	**DATE** **SIGNED BY SENIOR CORONER** 19.07.18