


	<p>REGULATION 28 REPORT TO PREVENT FUTURE DEATHS</p> <p>THIS REPORT IS BEING SENT TO:</p> <p>1. Chief Constable Francis Habgood QPM, Thames Valley Police, Oxford Road, Kidlington, Oxford, OX5 2NX chief.constable@thamesvalley.pnn.police.uk</p>
1	<p>CORONER</p> <p>I am Mr D M Salter, HM Senior Coroner for Oxfordshire.</p>
2	<p>CORONER'S LEGAL POWERS</p> <p>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.</p>
3	<p>INVESTIGATION AND INQUEST</p> <p>On 22 January 2019 I conducted the inquest into the tragic death of Simon Robinson who died at his home address of [REDACTED] on 2 February 2018. I returned a Narrative Conclusion as follows:</p> <p><i>Simon Robinson, aged 52, died on 02/02/2018 at his home address 20 Bridge Street, Oxford, being formally pronounced deceased at 15.43 hours.</i></p> <p><i>Simon Robinson had a long-standing mental health history of schizoaffective disorder and was suffering a psychotic episode when at approximately 14.27 hours he stabbed himself in the neck with a kitchen knife causing him to exsanguinate. Given his psychosis at the time he may not have been capable of forming a real intention to end his life. At about 14.27 hours his wife phoned 999 to request police attendance but the call was incorrectly graded resulting in a delayed response at approximately 15.15 hours. Given the likelihood that the injuries were sustained at about 14.27 hours it is possible but not likely that an immediate deployment and a response within 15 minutes may have enabled emergency medical treatment to have prevented his death.</i></p> <p>Thames Valley Police were legally represented at inquest. In addition to Mr Robinson's family, other 'Interested Persons' included Oxford Health NHS Foundation Trust (OH). Evidence was collated prior to inquest and a copy of the inquest file was provided to your legal department. The evidence at inquest included oral evidence from the police controller and, importantly, from Chief Superintendent Christian Bunt. Prior to inquest, I was provided with a copy of TVP's Critical Incident Review dated 17 July 2018 and a witness statement of Chief Superintendent Bunt dated 22 January 2019 along with other TVP documentation. I attach a copy of the review and statement for ease of reference.</p>

4	<p>CIRCUMSTANCES OF THE DEATH</p> <p>As will be seen from the above, Simon Robinson stabbed himself in the neck while suffering a psychotic episode at his home address on the afternoon of 2 February 2018 and bled to death. ██████████ made various telephone calls to TVP and OH. Firstly, ██████████ dialled 999 and spoke to the police controller at 14.27 hours and despite her concerns about her safety, she was advised to contact OH which she then did. Her concerns were not immediately escalated at OH either.</p>
5	<p>CORONER'S CONCERNS</p> <p>During the course of the Inquest the evidence revealed matters giving rise to concerns. 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 make this report to you.</p> <p>I should say that Chief Superintendent Bunt was a helpful and frank witness who provided helpful evidence. I appreciate that this matter raises difficult considerations involving communications between, for example, police and mental health services and also issues surrounding the extent of police powers.</p> <p>The MATTER OF CONCERN is in relation to the following:</p> <p>The concern that I have is mirrored in Chief Superintendent Bunt's statement paragraph 57 where it states that the current partnership agreement does not adequately cover incidents such as this one. The problem is the not uncommon situation where a person is experiencing a mental health crisis and there is an imminent need for agencies to respond. If the person is experiencing the mental health crisis is in their home or another private place, police powers are limited. I recognise there is a requirement to work in partnership with other agencies but the primary responsibility to respond when there is a fear for welfare or safety rests with the police. It should be the expectation therefore that the police will respond initially to deal with matters until other agencies are able to respond and take over if appropriate. It is concerning that there is a gap in the partnership agreement for a crisis situation such as this.</p> <p>I understood from Chief Superintendent Bunt that there was a need to formalise a plan at a strategic level to include consideration at inter-partnership meetings. It would be reassuring if the issue could be reviewed in this way and an action plan or similar agreed.</p>
6	<p>ACTION SHOULD BE TAKEN</p> <p>In my opinion action should be taken to prevent future deaths and I believe you have the power to take such action.</p>

7	<p>YOUR RESPONSE</p> <p>You are under a duty to respond to this report within 56 days of the date of this report. I may extend the period on request.</p> <p>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.</p>
8	<p>COPIES and PUBLICATION</p> <p>I confirm that a copy of this report and your response will be sent to Mr Robinson's family.</p> <p>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.</p>
9	<p><u>Signed</u> <u>Date</u></p> <p> Mr D.M. Salter HM Senior Coroner for Oxfordshire</p> <p style="text-align: right;"><i>7th March 2014</i></p>