North West Kent Coroners
Cantium House
County Hall
Sandling Road
Maidstone
Kent
ME14 1XD
[redacted]

Date: 25 May 2021
[redacted]

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| | **REGULATION 28 REPORT TO PREVENT FUTURE DEATHS**<br><br>**THIS REPORT IS BEING SENT TO: Chief Constable Kent Police; IOPC; [redacted]** |
| 1 | **CORONER**<br><br>I am His Honour Alan J Blunsdon for Kent County Council |
| 2 | **CORONER'S LEGAL POWERS**<br><br>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.<br><br>http://www.legislation.gov.uk/ukpga/2009/25/schedule/5/paragraph/7<br><br>http://www.legislation.gov.uk/uksi/2013/1629/part/7/m |
| 3 | **INVESTIGATION and INQUEST**<br><br>On 15 May 2020 I commenced an investigation into the death of Matthew MACKELL. The investigation concluded at the end of the inquest . The conclusion of the inquest was<br><br>Suicide with additional narrative: Matthew Mackell was found dead on the 7th May 2020 in Dunorlan Park, Tunbridge Wells, Kent. He had suspended himself from a tree using a ligature with the intention of taking his life. At 22:18 on the 6th May 2020 he had telephoned Kent Police to inform them of his intention but did not provide his identity or location. Kent Police did not deploy their available enhanced mapping system which would have provided an accurate location for Matthew Mackell. This was a missed opportunity, Kent Police did not maintain the correct "immediate" grading of the call. Kent Police did not despatch a patrol to the location of the deceased in response to the call. It was not possible to establish on the balance of probability whether the deployment of the enhanced mapping system would have resulted in a patrol finding Matthew Mackell before he was deceased.<br><br>1a Suspension<br><br>1b |

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| | 1c<br><br>II |
| 4 | **CIRCUMSTANCES OF THE DEATH**<br><br>Police were initially called on the morning of the 7th May 2020 by a runner in Dunorlan park. He stated that he and his wife had been running in the park and had seen a male hanging from a tree. Police then attended and located the deceased.<br>The body was initially found hanging from a tree in Dunorlan Park. A bedsheet had been used as a ligature. The tree was located around 50 metres in to the park from the Pembury Road entrance and was clearly visible from the footpath. The deceased was then cut down and CPR performed.<br>It appears that the deceased has had ongoing suicidal thoughts that have been aggravated by relationship troubles.On the evening before his death the deceased had an argument with his brother. At 2218 hours on Wednesday 6th May 2020 the deceased made a call to Kent Police Force Control Room in which he stated that he was going to kill himself.<br>No name or description was left and so the call could not be further explored. |
| 5 | **<u>CORONER'S CONCERNS</u>**<br><br>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.<br><br>The **MATTERS OF CONCERN** are as follows. –<br><br>(1) In December 2019 a software update had been installed to a system in the Kent Force Control room which, if used, produced a much greater accuracy in detecting the location of mobile phone calls. There had been inadequate or no training on the use of the update which resulted in the system not being deployed to locate the deceased. The call from the deceased at 22.18 was therefore incorrectly downgraded as the area to search was regarded as too wide to be effective. The downgrade was incorrect because (a) the use of the software would have provided an accurate location and (b) the call should have been treated as a suicide call and not an abandoned 999 call. It is accepted that as a direct result of this incident the software system is now the default setting to detect locations. However, the evidence of those witnesses who were required to use the system raised a more general enquiry which identified gaps in or absence of effective training and the cascading of information.<br><br>(2) The totality of the evidence from several experienced operatives in the Force Control Room revealed gaps in their knowledge as to operating procedure in respect of the suicide policy, appropriate downgrading of calls, checking available patrols. Whilst it is accepted that following an IOPC report steps have been taken to review and improve procedures, it was apparent that there was an absence of an effective system to identify those that required training/updating and of the keeping a record of the specific training/updating received by individual operatives and the date it was undertaken. There did not appear to be a structured system in place to produce a regular training rotation which monitored and recorded individual satisfactory progress. Such a system would clearly identify what training/updating had been received thus identifying those who might otherwise be missed and when training/updating was scheduled to take place.<br><br>(3) |

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| 6 | **ACTION SHOULD BE TAKEN**<br><br>In my opinion action should be taken to prevent future deaths and I believe you Kent Police have the power to take such action. |
| 7 | **YOUR RESPONSE**<br><br>You are under a duty to respond to this report within 56 days of the date of this report, namely by 21st July 2021 I, the coroner, may extend the period.<br><br>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**<br><br>I have sent a copy of my report to the Chief Coroner and to the following Interested Persons: IOPC, [redacted] and to the LOCAL SAFEGUARDING BOARD (where the deceased was under 18)].<br><br>I am also under a duty to send the Chief Coroner a copy of your response.<br><br>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 | 25 May 2021<br><br>Signature  <br><br>His Honour Alan Blunsdon Assistant Coroner for North West Kent |