Regulation 28: Prevention of Future Deaths report

Angela Rosemary BEST (died 15.12.16)

	THIS REPORT IS BEING SENT TO: **1. The Rt Hon Robert Buckland QC MP** **Lord Chancellor and Secretary of State for Justice** **c/o [redacted]** **Ministry of Justice**
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 19 January 2017, I commenced an investigation into the death of Angela Best, aged 51 years. The investigation concluded at the end of the inquest yesterday. I made a narrative determination at inquest, a copy of which I attach.
4	**CIRCUMSTANCES OF THE DEATH** Angela Best's former partner was convicted of her murder. He had already been convicted of the manslaughter of his wife in 1981 and then his partner in 1992.
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. The man who killed Angela Best was made the subject of a hospital order in 1993. He was discharged from hospital in 1997. One of the conditions of his discharge was that he had to disclose to his clinical and social supervisors if and when he entered into an intimate relationship with a woman. His risk to others was, over the years, consistently judged to be low if he was not in a relationship, but high if he was in a relationship. Knowing about a new relationship would allow the man's behaviour to be explored in a meaningful way by those treating him. It would allow the Ministry of Justice to be informed of the increase in risk. It would allow the woman to be informed of his history and to be offered specialist support, both during the relationship and if she chose to end it. It would allow more effective risk assessment and safety planning to try to protect her. In fact, he was in a relationship with Ms Best for approximately 20 years without detection. He killed her when she ended the relationship. The successive mental health trusts who acted as lead agency had the responsibility for *monitoring* the man's relationship status and his mental health (which never deteriorated). However, no person or organisation had the role, responsibility or power to *investigate* his relationship status. The monitoring of whether he was in a relationship was almost entirely based upon his *self* reporting. In fact, when this condition of discharge was imposed in 1997, the man was already known to have been untruthful about his relationship status. He continued to be untruthful about it. In such a situation, evidence may come to light via other agencies, for example if complaints of domestic violence are made to the police, but it did not in this instance. Thus, a matter important enough to be made a condition of discharge, depended upon the truthfulness and openness of an untruthful, two time killer who had a vested interest in withholding the relevant information. Unreliability was built in to the system.
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 2 August 2021. 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. • The family of Angela Best c/o [redacted], Deighton Pierce Glynn • Camden & Islington NHS Trust • Barnet, Enfield & Haringey NHS Trust • [redacted], general practitioner • HHJ Thomas Teague QC, the Chief Coroner of England & Wales I am also under a duty to send a copy of your response to the Chief Coroner and all interested persons who in my opinion should receive it. I may also send a copy of your response to any other person who I believe may find it useful or of interest. 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.
9	**DATE** **SIGNED BY SENIOR CORONER** 04.06.21 *ME Hassell*