REGULATION 28: REPORT TO PREVENT FUTURE DEATHS

	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO:** 1. The Chief Constable of Warwickshire Police
1	**CORONER** I am Tom Leeper, Assistant Coroner, for the coroner area of Warwickshire
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 16/11/12 an investigation was commenced into the death of Luisa Mendes (dob 12 April 1968). The investigation concluded at the end of the inquest on 02/06/16. The conclusion of the inquest was That the Deceased had died from ▪ 1a. Haemoperitoneum ▪ 1b. Peliosis of the spleen with rupture ▪ 2. Cirrhosis of the liver (alcohol) The Jury returned a narrative conclusion which included findings that there were errors or omissions, which possibly caused or contributed to the death, in the following areas involving the Warwickshire Police: • in the response to telephone calls made to the Police on the evening of 24 October 2012 in not upgrading the categorisation of the incident from rowdy to nuisance; • in the handover process between controllers; • in the deferring of a response to the incident until the following morning; • in the ability of controllers to configure the display on their computer screens; • in the supervision of the control room over 24-25 October 2012.

4	**CIRCUMSTANCES OF THE DEATH** On 25 October 2012, between 1000 and 1100 hours, Luisa Mendes was pronounced deceased at 27 Briar Close, Leamington Spa. The death was due to a catastrophic bleed to the abdomen caused by a rupture to her spleen. The rupture was a result of a deliberate application of force by a third party caused during or after telephone calls to police on the evening of 24 October 2012.
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. In the circumstances it is my statutory duty to report to you. The **MATTERS OF CONCERN** are as follows. – (1) The approach of controllers and call handlers to the categorisation of incidents which include allegations of violence. The basis for the concern is that the incident should have been categorised as "violent" but it was not. (2) The handover procedures between controllers coming on and off shift in the Operations and Communications Centre. The basis for the concern is that there are no formalised procedures and no specific training in relation to handovers between controllers coming on and off shift. (3) The set up of the STORM computer system as it relates to deferrals. The basis for the concern is the absence of any feature on the STORM computer system which will alert management to the effect that an unauthorised deferral has been effected by a controller.
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 25/08/16 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 Chief Coroner and to the Interested Persons.

	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	**DATED** 30/06/16 **T.R.G.LEEPER** **[SIGNED BY CORONER]**