	REGULATION 28 REPORT TO PREVENT DEATHS **THIS REPORT IS BEING SENT TO:** **1 Chief Constable for Thames Valley Police, [redacted]** **2 Chair of National Police Chiefs' Council, [redacted]**
1	**CORONER** I am HEIDI J CONNOR, Senior Coroner for Berkshire for the coroner area of Berkshire
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. It is important to note the case of *R (Dr Siddiqui and Dr Paeprer-Rohricht) v Assistant Coroner for East London*. This case clarifies that the issuing and receipt of a Regulation 28 report entails no more than the coroner bringing some information regarding a public safety concern to the attention of the recipient. The report is not punitive in nature and engages no civil or criminal right or obligation on the part of the recipient, other than the obligation to respond to the report in writing within 56 days.
3	**INVESTIGATION and INQUEST** The family requested me to refer to the deceased as Angela. I will reflect that in this report. I conducted an inquest into the death of Angela Mittal which concluded on 26th of July 2024. The conclusion of the jury was as follows: Angela was unlawfully killed. The following Thames Valley Police findings have been admitted: a. The officers who spoke to Angela on 29th of November 2018 did not recognise that she was reporting the crime of coercive control. b. The officers who spoke to Angela on 29th of November 2018 did not record the crimes she reported, either of assault or coercive control. c. The officers who spoke to Angela on 29th of November 2018 accepted that the risk grading on the DOM-5 risk assessment form should have been medium rather than standard. d. The senior officer who saw Angela on 29th November 2018 accepted that he did not fully review the DOM-5 risk assessment form before signing it. e. The officers who spoke to Angela on 29th November 2018 did not take information available to them (on the command and control system used then, from a call Angela had made to the police earlier that morning) into account in their assessment of risk. This was despite the call handler identifying domestic violence and coercive control in the course of that 16 minute telephone call. f. The officers who spoke to Angela on 29th November 2018 did not investigate the crimes Angela reported to them that day.

	Based on all the evidence heard in court, we the jury conclude that the admitted failings of Thames Valley Police, on the balance of probabilities, did not contribute to Angela's death.
4	**CIRCUMSTANCES OF THE DEATH** Angela was murdered at her home address by her husband on 26th of December 2018. She was 41 years old at the time of her death. We heard in evidence that Angela had spoken to Thames Valley Police by telephone and in person on the 29th of November 2018. She reported an allegation of assault around a month prior to that, and also many of the elements of coercive control. She also reported an assault on her young child to the call handler, but this was not recorded as a crime, nor handed over to the police officers who saw her that day. Because of the involvement of a child in the family home, a referral was made to the Multi-Agency Safeguarding Hub within Wokingham Borough Council Children's Services. A decision was made to carry out a Child and Family Assessment under Section 17 of the Children Act of 1989. Angela had moved out of the marital home whilst she was in contact with the social worker at Wokingham Borough Council. Although she had discussed the possibility of returning to the marital home, she did not tell the social worker of a definite plan to do so. Tragically, and against her family's advice, Angela returned home on the evening of 25th of December 2018. Her husband rang Thames Valley Police the following morning to tell them that he had murdered his wife. Before this inquest took place, a criminal trial and a domestic homicide review had been undertaken. It is important to acknowledge, in relation to the concerns listed below, that the death occurred some five and a half years ago.
5	**CORONER'S CONCERNS** During the course of the investigation my enquiries 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. Given the likelihood that the areas of concern relate not just to the police force in my jurisdiction, I have addressed this report to the National Police Chiefs' Council. I note that the website of the NPCC currently lists violence against women and girls as the first area of work that they are focusing on. Thames Valley Police's own training confirms that coercive and controlling behaviour is a major risk factor in domestic homicide.

	The **MATTERS OF CONCERN** are as follows: (Brief summary of matters of concern) 1. Whether sufficient steps have been taken to ensure that frontline staff have a clear understanding of domestic abuse and coercive and controlling behaviour – to think not just about physical abuse, but also about controlling behaviour and how that may escalate. 2. I am concerned that Thames Valley Police's DASH risk assessment form (called a DOM5) does not make it sufficiently clear that the definition of "serious harm" can include psychological harm from coercive and controlling behaviour. It may be that other formulations of this document nationally do make this clear – I have looked only at the form used by Thames Valley Police. 3. I heard evidence about a new tool for risk assessing domestic abuse, created by the College of Policing. Both the senior Thames Valley Police officer and the College of Policing witness gave evidence that this system is likely to result in better risk assessment for domestic abuse. As I understand it, this new tool has not been adopted by Thames Valley Police at this time, because of competing financial priorities, and an issue with compatibility with the Niche system.
6	**ACTION SHOULD BE TAKEN** In my opinion action should be taken to prevent future deaths and I believe you (and/or your organisation) 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 the 8th of October. 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 Angela's family, via their legal representative. I have also sent this report to the following recipients, who have an interest in this matter: 1. Legal representatives for Thames Valley Police. 2. Legal representative for Wokingham Borough Council. 3. College of Policing. who may find it useful or of interest. The above recipients are not expected to respond to this

	report. 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: 13/08/2024**  **HEIDI J CONNOR** **Senior Coroner for Berkshire for Berkshire**