REGULATION 28: REPORT TO PREVENT FUTURE DEATHS

	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO:** 1. **Commissioner of the Metropolis, c/o Directorate of Legal Services, 1st Floor, Victoria Block, New Scotland Yard, 8-10 Broadway, SW1H 0BG**
1	**CORONER** I am Nadia Persaud, Senior Coroner for the Eastern Area of Greater London
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. http://www.legislation.gov.uk/uksi/2013/1629/part/7/made
3	**INVESTIGATION and INQUEST** The investigation into the death of PAULS RICARDS KALNINS commenced on the 9th July 2014 and concluded on Friday 10th July 2015. The inquest concluded with a conclusion of suicide.
4	**CIRCUMSTANCES OF THE DEATH** Mr Kalnins, who was aged 19 at the time of his death, had a history of depression. His mental state deteriorated significantly in May 2014. On the 31 May 2014 he went missing from home and he was reported to the police as a missing person. He returned of his own volition on the 2nd June 2014. After his return, he was very withdrawn. An incident occurred, whereby he lay in the road in the early hours of the 23rd June 2014, resulted in him being taken to Newham General Hospital. On this occasion he complained of hearing voices telling him to harm himself. He left the hospital before assessment and he was reported missing by his mother later that day. On the 5th July 2014, Mr Kalnins was spoken to by 4 police officers on routine patrol. He was found sitting under an underpass. Checks of the PNC revealed he had been reported as a missing person and had discharged himself from hospital. Further checks through the support channel were made and the officer requested further information be provided, from the Merlin database. The communications officer did not identify any concerns about Mr Kalnins' mental health and he could not locate a telephone number for Mr Kalnins' next of kin. The Merlin database did contain the next of kin's telephone number and also the fact that his mother was concerned that Mr Kalnins might harm himself, due to his mental state. When the officers returned to the station some hours later, to update the Merlin database, they found the additional information. Attempts were made to return to Mr Kalnins. Unfortunately, Mr Kalnins, had left the location and could not be found. The following day, he was found hanging in a shed to the rear of Foresters apartments in Barking, Essex.
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. – (1)The communications officer confirmed that he had worked in his role for 15 years, but

	had had little need to obtain data from the Merlin database. Whilst he therefore had access to it, he was not familiar with it. He confirmed that he had last had training in 2011, in relation to the database. (2) The communications officer said that he did not know where to look for the required details. He explained that the database is complex to navigate. The front screen does not contain any key information relating to risk. (3) An investigation was carried out by the Directorate of Professional Standards and they found that the communications officer had accessed the correct pages of the Merlin database but had failed to see the relevant pieces of information. (4) The line manager for the communications officer concerned, confirmed that it would "100% assist if key risks come up automatically on the front screen of the Merlin database". (5) She confirmed that the communications officers are under a lot of pressure when they provide information to officers on the ground; they do not need to access the Merlin database regularly and have to go through a lot of detail in the database. She agreed that refresher training for communications officers would also be useful. (6) The investigator from the Directorate of Professional Standards, [redacted] also agreed that the Merlin database is a piece of software which could be improved and could be more user-friendly. He agreed that Merlin is an important database and it would be useful to have refresher training. (7)It was considered that the identification of the grade of risk (low, medium or high) on the front page, together with a brief explanation as to the type of risk posed, is likely to assist in prompting the communications officer to undertake a more detailed search of key parts of the database. [redacted] suggested that the warning could be in red. Having heard all of the above evidence, I consider that if the key risks could be highlighted on the front screen of the Merlin database, this would greatly assist communications officers and reduce risk to vulnerable persons in the future. Mandatory refresher training for communications officers, may also reduce risk.
6	**ACTION SHOULD BE TAKEN** In my opinion action should be taken to prevent future deaths and I believe 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, **9 September 2015.** 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 mother of the deceased [redacted] I am also under a duty to send the Chief Coroner a copy of your response. I will also forward a copy of your response to [redacted] 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	**15 July 2015 [SIGNED BY CORONER]** [redacted]