REGULATION 28: REPORT TO PREVENT FUTURE DEATHS

	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO:** **Chief Constable Dyfed-Powys Police**
1	**CORONER** I am Jonathan Mark Layton, Senior Coroner for the coroner area of Carmarthenshire and Pembrokeshire.
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 30th December 2016 I commenced an investigation into the death of Michaela Marie Haines who died on 23rd December 2016. The investigation concluded at the end of the inquest on 23rd November 2017. The conclusion I recorded was an open conclusion.
4	**CIRCUMSTANCES OF THE DEATH** (1) At approximately 02.36hrs on 23rd December 2016, police were dispatched to deal with a report of a female hanging in the stairwell of flats at Tenby Mount, Tenby. (2) A STORM (System for Tasking and Operational Resource Management) Command and Control System incident report was created and up-dated with developments as the investigation continued. (3) The STORM report identified the need to follow up enquiries with the occupants of persons living within the block of flats. It is not clear whether enquiries were followed up with the occupants of the block of flats as no record of such enquiries has been entered onto STORM. (4) The STORM report further identified that CCTV covered the stairs and would show anyone approaching the stairs. Whilst there was some evidence before the inquest that this did not operate, the STORM report was not updated to confirm the position. (5) CCTV from a local hotel was requested from the proprietors who preserved the same for police. They believe this was collected from them but it has not been entered into the property log. Had the STORM report been fully completed identifying this as a task and then recording steps taken to complete this task, then any issue as to whether this piece of evidence had been secured would have been resolved, thus avoiding the distress it caused to the family.
5	**CORONER'S CONCERNS** During the course of the inquest the evidence revealed this matter 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** is as follows: The STORM report had not been up-dated with actions taken. This caused uncertainty as to whether outstanding enquiries had been actioned or not. This may have resulted

	in evidence not being preserved. It could also result in work being duplicated with enquiries being made when they have already been undertaken. If the STORM report is to be used as an effective command and control document it is essential that it is updated in the light of changing developments. Training may be required to remind those using this vital work tool of the need to keep it up to date.
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 the 18th January 2018. 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 following Interested Person: [redacted] Chief Constable, Dyfed Powys Police, Police Headquarters, PO BOX 99, Llangunnor, Carmarthen, SA31 2PF 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	**23rd November 2017** **Signed:**