Regulation 28: Prevention of Future Deaths report

Rosario CORDERO-SANZ (died 14.08.18)

	THIS REPORT IS BEING SENT TO: **1. Commander David Musker** **Metropolitan Police Service** **New Scotland Yard** **Victoria Embankment** **London SW1A 2JL**
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 17 July 2018, one of my assistant coroners, Sarah Bourke, commenced an investigation into the death of Rosario (known as Charo) Cordero-Sanz. The investigation concluded at the end of the inquest on 22 October 2018. At inquest, the jury made a narrative determination, which I attach. The medical cause of death recorded was: 1a multiple injuries 1b blunt force trauma

4	**CIRCUMSTANCES OF THE DEATH** Charo Cordero-Sanz jumped in front of a train at Bethnal Green Underground Station at around noon on Saturday, 14 July 2018. The jury determined that she was at the time acutely unwell. On Wednesday, 11 July 2018, London Ambulance Service had attended her home, following a concern for her mental health. However, she declined hospital admission and so was advised to sign on with a general practitioner and to access mental health services via the GP surgery. In the early hours of Friday, 13 July, she was reported to the Metropolitan Police Service as a missing person. Friends had not seen her since late Wednesday evening. She was graded as a high risk missing person and police made considerable efforts to locate her. Late that Friday evening, Ms Cordero-Sanz returned to her friends, but did not seem to be well. They called police again and three special police officers attended that night. After the officers left, Ms Cordero-Sanz ran away. Despite a search, her friends could not find her. Later that day she jumped in front of the train.
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. MPS special police officers are not issued with tablets as regular officers are, yet the three on duty who attended on Friday night / Saturday morning were given one of the police vans that is not equipped with an on board computer. This meant that they could not check details on police computer systems themselves. Instead, they had to radio for assistance. 2. In addition, the jury heard as follows. - The three police officers did not appear to have an in depth understanding of the misper process.

	- They did not (save for one who had attended such calls before) appear to have an in depth understanding of the s136 Mental Health Act / mental health potential issues. - They did not consider using language line to assist them in obtaining information from the non native English speaking friend, with whom they spoke outside the building where Ms Cordero-Sanz was staying with a friend. Being able to speak in his native language might have facilitated the informant to give fuller details, such as the fact that Ms Cordero-Sanz was by now hearing voices. - Having been told that she would be upset by their uniforms, they did not insist on seeing Ms Cordero-Sanz to assess her for themselves, or call for the assistance of a plain clothes colleague, or suggest that they speak to the friend who was sitting inside with her. - Nobody thought of calling an ambulance that night, save for the CAD (computer aided despatch) operator who took the call in the first place, but he did not mention he had done so to anyone else. I wonder whether this suggests a training need, and/or whether, given the difficulties in maintaining skills on only 15 hours a month, consideration could be given to teaming special officers with regulars? 3. The three special police officers who attended late that Friday evening / early Saturday morning were described as kind, and clearly demonstrated concern, but ultimately they did not know that they were dealing with a high risk missing person. Without tablets or a mobile data terminal, they had no means of checking this themselves. The jury found that the special sergeant and the CAD operator did not actively listen to one another. This meant that the Merlin system was not checked again after officers had obtained Ms Cordero-Sanz's full name, missing the opportunity to match her details with those reported earlier and to identify her as a high risk misper. 4. There was not a full understanding among the CAD operators of how to search with only part of a name e.g. CORDERO* as a wild card. This seems a significant omission in the understanding of those fulfilling that role.
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 24 December 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 following. • HHJ Mark Lucraft QC, the Chief Coroner of England & Wales • [redacted], sister of Charo Cordero-Sanz 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 Senior Coroner, at the time of your response, about the release or the publication of your response by the Chief Coroner.
9	**DATE** **SIGNED BY SENIOR CORONER** 29.10.18