ANNEX A

REGULATION 28: REPORT TO PREVENT FUTURE DEATHS (1)

NOTE: This form is to be used after an inquest.

	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS
	THIS REPORT IS BEING SENT TO:
	 Worcestershire Safeguarding Childrens Board 3.
1	CORONER
	I am Geraint Urias Williams, Senior Coroner, for the coroner area of Worcestershire
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 3 rd March 2011 I commenced an investigation into the death of Dana Louise Baker then aged 16 years.
	The investigation concluded at the end of the inquest on 29 th May 2014. The conclusion of the inquest was suicide contributed to by a failure to protect from a known risk of suicide, the medical cause of death being hanging.
4	CIRCUMSTANCES OF THE DEATH
,	Dana Louise Baker was a looked after child under the care of Worcestershire County Council. It was known that a breakdown of her foster placement would lead to extreme distress with a consequent risk that she might kill herself.
	When the placement did breakdown Dana was allowed to stay with an adult friend and the following day she hanged herself in a public place.
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) As outlined in the IMR's, the Serious Case Review and the draft Overview Report there was a lack of knowledge and understanding as between various agencies involved with Dana and inadequate communication between them.
	(2) The IMR's are kept confidential and not even shared as between Agencies concerned. Some IMR authors indicated that they could not comment on areas of "mutual concern" because they were unaware of the content of other Agency's IMR's.
	(3)

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	(3)
	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 by way of considering whether IMR's should be routinely shared as between individual Agencies so that a full picture of any identified failings can be produced.
7	YOUR RESPONSE
	You are under a duty to respond to this report within 56 days of the date of this report, namely by 23 rd July 2014 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 Persons Chief Executive of Worcestershire Acute NHS Hospitals Trust, Chief Executive of South Staffordshire NHS Trust, Chief Executive of Child Care Bureau, Chief Executive of Worcestershire County Council and Chief Executive of Health and Care Trust.
	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	Signed
	Signed 9
	G U Williams 29th day of May 2013 H M Senior Coroner