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:** 1. [redacted] 2. **Mr Will Tuckley, Chief Executive of Bexley Social Services, Civic Offices, 2 Watling Street, Bexleyheath, Kent DA6 7AT** 3. **Mr Andy Marshall, Chief Executive of Ethelbert's Children's Services, Director Cheesemans Farmhouse, Alland Grange Lane, Manston, Kent CT12** 4. [redacted] **Borough Commander Metropolitan Police Services for Greenwich Borough, Greenwich Police Station, 31 Royal Hill, Greenwich SE10 8RR**
1	**CORONER** I am Lorna Tagliavini Assistant Coroner, for the area of Inner London South
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 4th July 2012 an inquest was opened into the death of Lauren Barfoot aged 14 years. The inquest concluded on 1st August 2014 after an inquest held on 31st July and 1st August 2014. The conclusion of the inquest was: "**Accidental death contributed to by failures in the sharing of information and pooling and use of resources by those in whose care Lauren was in at the time of her death.**"
4	**CIRCUMSTANCES OF THE DEATH** On 22nd April 2012 Lauren became a "looked after child" pursuant to section 20 of the Children's Act 1989 and was placed in Micawber House ("the home") by the London Borough of Bexley Social Services, a home run by Ethelbert's Children Services. From the outset, Lauren was frequently missing from Micawber House although would most often return the following day at the latest. On 22nd June 2012 Lauren went missing from the home and was reported by the staff at the Home to the MPS, and treated as a missing person by the Missing Person's Unit (Greenwich Borough) from that date until her discovery in the porch of her putative father's home address in the Plumstead, London SE18 area
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) There was a failure by the London Borough of Bexley Social Services to record and make accessible, a comprehensive list of Lauren's friends, family and acquaintances and their addresses and contact numbers, with whom contact could be made in order to assist professionals in an effective search for Lauren. (2) There was a failure by Ethelbert's Children's Services to relay full and detailed information to the Missing Person's Unit (Greenwich) as to the level of risk classified as "high" in relation to Lauren's misuse of solvent abuse and vulnerability of sexual exploitation. (3) There was a failure by the MPS Missing Person's Unit (Greenwich) to carry out an effective search for Lauren as a consequence of the lack of information not shared with the Unit by those responsible for looking after and searching for Lauren, and therefore a missed opportunity for the Missing Person's Unit to classify Lauren as a "high risk missing person". (4) There was a failure by The London Borough of Bexley to hold a timely "strategy meeting" by those concerned in the care for Lauren after she had been missing for several days in order to pool information and resources in order to catty out an effective search for Lauren.
	ACTION SHOULD BE TAKEN In my opinion action should be taken to prevent future deaths and I believe your organisations have the power to take such action. For example: (i) A full and regularly updated list of persons by both the London Borough of Bexley Social Services and Ethelbert's Children's Services with whom a "looked after" child is connected in order, to be able to make meaningful searches after absconding/missing. This list to be kept centrally or is readily accessible, whether electronically or in another format. (ii) The sharing of details of any relevant risk assessment carried out in respect of the missing child should be passed to the police in order they can make a properly and fully informed decision as to the level of resources needed in order to carry out an effective search. (iii) The holding of a timely strategy meeting at which information can be pooled and resources allocated and utilised effectively. (iv) The means by which the Missing Persons Unit (Greenwich) is able to access essential information in respect of a missing person, in order to carry out n effective prioritisation of resources required for any search.
7	**YOUR RESPONSE** You are under a duty to respond to this report within 56 days of the date of this report, namely by 23rd October 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, [redacted] mother), the London Borough of Bexley, Ethelbert's

	Children's Services, the MPS and the Bexley Local Safeguarding Board as Lauren was under 18. 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	**DATE** **28 August 2014** **SIGNED BY CORONER LM Tagliavini**