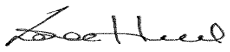
	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO:** **Rt Hon David Gauke MP – Ministry of Justice** **Home office**
1	**CORONER** I am Mrs Louise Hunt HM Senior Coroner for **Birmingham and Solihull**
2	**CORONER'S LEGAL POWERS** I make this report under paragraph 7, Schedule 5, of the Coroners and Justice Act 2009 and regulations 28 and 29 of the Coroners (Investigations) Regulations 2013.
3	**INVESTIGATION and INQUEST** On 22/01/2014 I commenced an investigation into the death of Jacqueline Oakes. The investigation concluded at the end of an inquest on 11 October 2018. The conclusion of the inquest by the jury was "To conclude, the victim was killed unlawfully. However the victim was also a vulnerable lady which was a factor in her making a number of naive decisions, despite knowing the offenders history. Following the inappropriate placement of the offender in the same property as the victim, a relationship between the 2 developed. The offender committed numerous offences which failed to lead to any prosecution. The support that the victim needed was available although Domestic Abuse (where identified) and mental health sufferers need extra attention due to their sensitivity and complexity and this wasn't always provided."
4	**CIRCUMSTANCES OF THE DEATH** Jacqueline Oakes suffered from mental health difficulties and was vulnerable and at the end of 2012 she became homeless and moved into supported living accommodation in January 2013. It was there that she met [redacted] who had recently been released from prison for a serious offence against his previous partner. [redacted] had been sentenced to 30 months in custody with extended licence for 24 months. He had been released on parole on 12/11/09 but was recalled to prison several days later on 14/12/09 as he had missed his curfew and failed to attend a meeting with his probation officer. After his return to prison he was refused further parole and was released on 11/02/13 at the end of his sentence. His last Oasys assessment had confirmed him to be a high risk to future partners and a medium risk to the public. He was MAPPA Cat 2 level 1. As he had served his full sentence no agencies were notified about his release. [redacted] met Jacqueline at the beginning of April 2013. [redacted] was abusive to Jacqueline and frequently assaulted her. He was arrested and charged with 3 counts of assault and harassment (fear of violence) in June 2013 but Jacqueline later retracted her statement and he was released. Further assaults occurred in September 2013 and he was again arrested and charged with assault. He was released on 04/11/13 as Jacqueline had provided a retraction statement and a victimless prosecution was unsuccessful. There were further assaults in December 2013 and January 2014 and [redacted] was arrested on 08/01/14 but later bailed pending further enquiries. On 14/01/14 Jacqueline's body was found in the flat where she was staying and [redacted] was convicted of her murder on 15/07/14 and sentenced to a minimum term on 18 Years in prison. Following a post mortem/Based on information from the Deceased's treating clinicians the medical cause of death was determined to be: 1a. MULTIPLE INJURIES
5	**<u>CORONER'S CONCERNS</u>** 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. When an offender is released having completed their full sentence who is known to be a high risk to others there is no mechanism for any other agencies to be alerted to that person's release. Had an alert been provided to other agencies that came into contact with Jacqueline and [redacted] it would have meant they were better able to manage the risks he posed. Consideration should be given to whether such alerts can be provided.
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 11 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 Chief Coroner and to the following Interested Persons: Family Probation service Birmingham and Solihull Mental Health trust Birmingham City Council Police Federation [redacted] Swanswell Sustain West Midlands Police 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	16/10/2018 Signature  Mrs Louise Hunt HM Senior Coroner **Birmingham and Solihull**