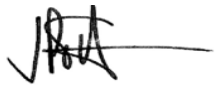
	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO:** 1. [redacted], Independent Chair, Shropshire Safeguarding Children's Board, The Shropshire Safeguarding Partnership, Shropshire Council, Room GN94, Ground Floor, Shirehall, Abbey Foregate, Shrewsbury SY2 6ND 2. Ms Jacky Tiotto Chief Executive of CAFCASS, 16th Floor, Southern House, Wellesley Grove, Croydon, Surrey, CR0 1XG.
1	**CORONER** I am Mr John Penhale Ellery, Senior Coroner, for the coroner area of Shropshire, Telford & Wrekin.
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 the 22nd September 2017 I commenced an investigation into the death of Archie David SPRIGGS, 7 years of age. I opened an inquest on the 26th September 2017 and adjourned it on the 23rd January 2018, having suspended my investigation pending criminal proceedings brought against Archie's mother Leslie Speed for his murder. Following her conviction for his murder and completion of a Serious Case Review (SCR) by Shropshire Safeguarding Children's Board (SSCB). I resumed the inquest on the 2nd April 2019 which was heard on the 11th, 12th, 14th, 19th, 20th & 21st November 2019. The medical cause of death was Ia) Pressure to the neck with features raising the prospect of occlusion of the external airways. The conclusion of the inquest followed the outcome of the criminal proceedings and was "Unlawful Killing".
4	**CIRCUMSTANCES OF THE DEATH** Archie was murdered by his mother on the morning of the 21st September 2017. Archie was the subject of a bitter and acrimonious dispute between his parents. A child arrangements hearing was due to take place that day at Telford County Court. Archie and his parents were known to Social Services (and other agencies). Opportunities were lost to hear Archie's voice in 2014 and 2017 but they cannot be said to have been causative of his death.
5	**CORONER'S CONCERNS** During the course of the investigation matters were raised giving rise to concern. Although they could not be said to be causative of Archie's death 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. These concerns are based upon the SCR whose author was [redacted], Independent Safeguarding Consultant. Whilst the SCR is a public document feeding into it were 15 Individual Management Reviews (IMRs) which predated the SCR and are restricted documents.

	The concerns are covered within the 8 recommendations of the SCR which, for consistency of approach, I adopt. The 8 recommendations are set out verbatim as follows: a) SSCB to clarify, and subsequently audit the application of the referral pathway and decision-making process for referrals to Early Help and Children's Social Care. This should include the use and quality of written referral forms and feedback to referrers. b) SSCB to seek regular assurance that: i. Professionals understand how to refer urgent concerns in respect of cases open to Children's Social Care; ii. Children's Social Care provide a timely and child centred response to this information. c) SSCB to provide the multi-agency workforce with the knowledge and understanding of i. the impact of protracted private law proceedings on children's emotional wellbeing; ii. the factors to be considered and assessed in circumstances whereby separated parents make allegations about the welfare of their children iii. the features of filicide cases. d) To test the impact of recommendation (c) SSCB to conduct a multi-agency audit of the services provided to children referred to Children's Social Care whose parents are separated and where private law proceedings have taken place. The audit should consider the completion of whole family assessments and the response to safeguarding concerns and allegations of domestic abuse. e) SSCB to work with Local Family Justice Board (LFJB) and CAFCASS to review the notification process for Section 37 reports to ensure timely and consistent arrangements. f) CAFCASS to update their Child Protection Policy to include when and how safeguarding referrals (child in need) should be made. g) SSCB to engage with multi-agency frontline staff as well as parents/carers to explore their experiences, and any barriers, to working with fathers. The findings of this work should be considered and acted on by SSCB. h) SSCB to create learning opportunities for the multi-agency workforce to come together and reflect on their approach to providing a whole family focus; including how they consider the impact of parenting capacity on children. This Regulation 28 report is directed to the SSCB so they with CAFCASS may provide a holistic approach with collective responses from those feeding in to the SCR as may be appropriate.
6	**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.

7	**YOUR RESPONSE** You are under a duty to respond to this report within 56 days of the date of this report, namely by 27th January 2020. 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: Birnberg Peirce Solicitors – [redacted], representing [redacted] Shropshire Council – [redacted] West Mercia Police – [redacted] and to the Local Safeguarding Board (including the Child Death Overview Panel). 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	 Mr John Penhale Ellery Senior Coroner Shropshire, Telford & Wrekin 2nd December 2019