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:** Secretary of State for the Home Department Secretary of State for Justice Secretary of State for Health and Social Care
1	**CORONER** Lorraine Harris, Area Coroner, East Riding of Yorkshire and City of Kingston Upon Hull.
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 7th February 2018 an investigation into the death of Jessica Louise LAVERACK "Jessie", age 34 years, was commenced. The investigation concluded at the end of the inquest on 27th June 2022. The conclusion of the inquest was: Narrative: *Jessica Louise Laverack was vulnerable due to a history of domestic abuse and anxiety, her emotional distress caused alcohol dependence. On 2nd February 2018, Jessie was found* [redacted] *The level of alcohol in her system would have impaired her cognitive function.* *The lack of an appropriate, co-ordinated approach to her issues, which was further hampered by inadequate information sharing, while not directly causative of her death, would have affected the state of her mental health and contributed to her decline.* MCCD: 1a Hanging I have attached a copy of my findings of fact, and reasonings regarding conclusion.
4	**CIRCUMSTANCES OF THE DEATH** [redacted] Jessie had a history of domestic abuse. She suffered from anxiety and had a history of alcohol dependence which was a way she coped with emotional distress.

	Jessica reported domestic abuse, [redacted] Jessie was advised to move home in order to keep herself safe. Her MARAC status was moved from Rotherham to Beverley. After hearing the case in a hearing where she was allocated, as was the norm, a maximum of 10 minutes her case was archived. There followed a series of incidents whereby her ex partner was attempting to obtain her address and was contacting her family. Between August and January while interacting with a number of agencies including the police she disclosed the fear that she was living in, she further reported on occasion suicidal ideation and she attended A&E with cut wrists. However, it was noted that she was motivated to get well. Her treatment focused on her alcohol use rather than an holistic approach to someone with a dual diagnosis. The matter was not referred back to MARAC as it was not deemed high risk There was not a structured co-ordinated approach to her care, and there was a lack of information sharing. There was contact with Jessie and her ex partner leading up to her death. [redacted]
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 could 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) The is a need for the recognition of the link between domestic abuse and suicide. Processes and policies do not seem to include this serious area to the extent that is required. (2) There is no system to appropriately identify and care for the vulnerable who do not meet the criteria of "high risk" which is covered by MARAC, evidence was heard that a large number of domestic homicide reviews cover victims who have not been rated as "high risk" (3) There was a lack of information sharing between all agencies, even those tasked with domestic abuse. a. There is no one database which is accessible for all agencies to input their common concerns. b. There is lack of robust policy of information sharing regarding both suicidal ideation, self harm as well as identification of the vulnerable. It is noted that the Health and Care Act is due to commence on 1st July 2022, which outlines need for interagency working. This may be an ideal opportunity to address these issues. (4) There is no single point of contact to oversee the collation of all

	information, to appropriate assess it and to coordinate a structured proactive approach to people with dual or multi diagnosis. This is in both MARAC and for those who are vulnerable but do not meet the "high risk" criteria. (5) There is a need to consider better training and awareness of both domestic abuse and risk of suicide for front line police officers. (6) Consideration to be given to whether the deployment of front line officers to deal with domestic abuse is appropriate, and whether this should be referred to police adult safeguarding in the same way that criminal investigations are often elevated to CID. (7) Evidence was heard that the DASH form may benefit from updating. (8) The processes of Humber police's vulnerability hub and DARA forms which show a more proactive, collative approach, are not currently a nationally recognised method of working. (9) If not already in place, to consider complex case forums on a national level. (10)Consideration as to whether GP's and other voluntary organisations/non-statutory organisations should be invited to MARAC (11) To consider better information sharing about the risks of sleep deprivation and its impact on mental health and suicide. (12) I was requested to consider placing MARAC on a statutory footing in line with an earlier RPFD , I merely highlight this report – 2019 Andrew Harris, Senior Coroner for Inner North London in the inquest touching the death of Donna Williamson, RPFD addressed to Secretary of State for Home Affairs and Secretary of State for Health and Social Care).
6	**ACTION SHOULD BE TAKEN** In my opinion action should be taken to prevent future deaths and I believe you and your department have the power to take such action. Please note that this has been sent to 3 ministers as a joint approach to many of the issues is required.
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 August 2022. 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: • The Victims Commissioner • The family of Jessica Louise Laverack "Jessie" via their advocates [redacted]

	• Humberside Police Service • South Yorkshire Police Service • East Riding of Yorkshire Council • Humber Teaching NHS Trust • MIND • [redacted] • The Beverley Health Centre I am also under a duty to send a copy of your response to the Chief Coroner and all interested persons who in my opinion should receive it. I may also send a copy of your response to any other person who I believe may find it useful or of interest. 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.
9	**[DATE]** **[SIGNED BY CORONER]** ***27th June 2022*** ***Lorraine Harris***