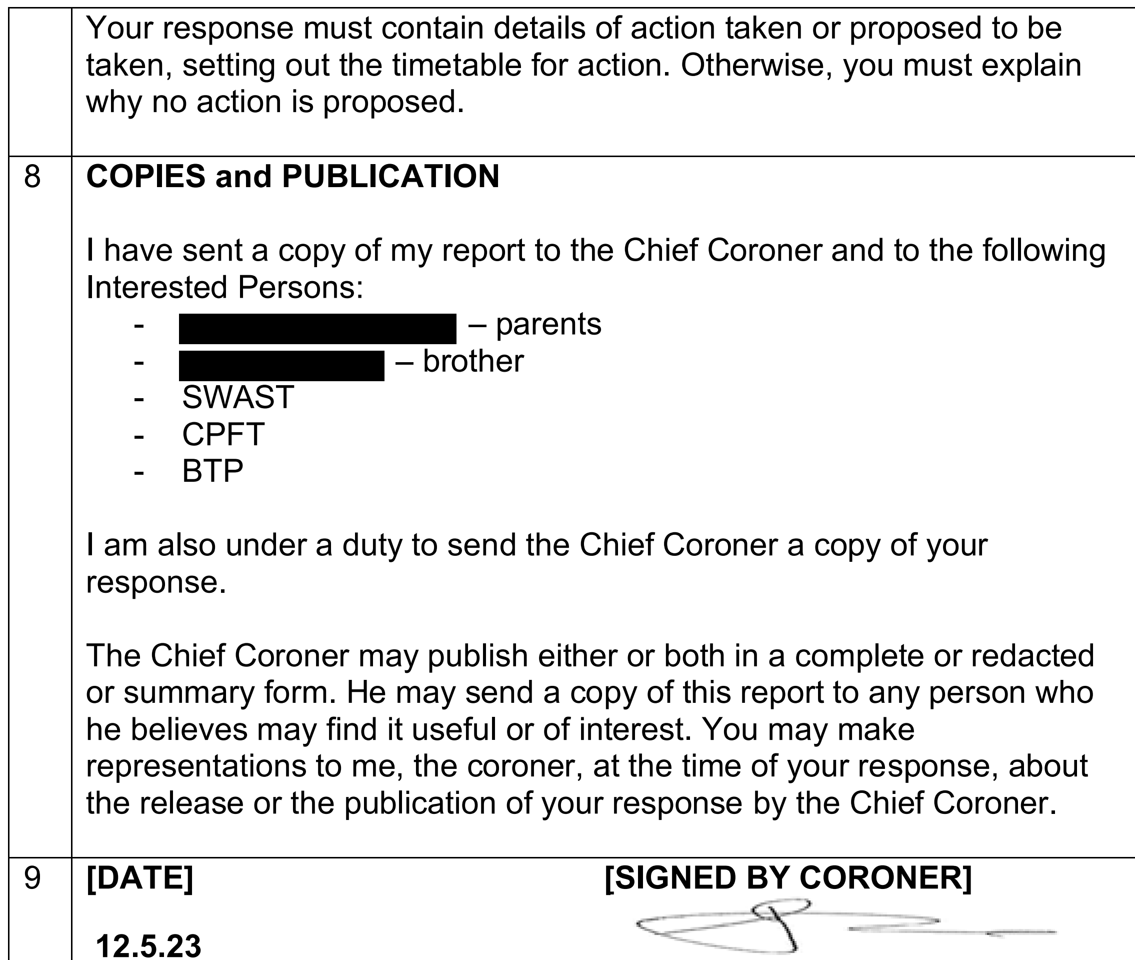
*NOTE: This form is to be used **after** an inquest.*

	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO:** **1. [redacted], Chief Constable, Devon & Cornwall Police, with a copy for information only (ie no duty to respond) to** **2. [redacted], Police & Crime Commissioner**
1	**CORONER** I am Andrew Cox, the Senior Coroner for the coroner area of Cornwall and the Isles of Scilly.
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 12.5.23, I concluded an inquest into the death of Tamsin Ann Dolamore who died at the age of 24 on 9.1.18. . The medical cause of death was recorded as: 1a) Effects of multiple injuries 1b) 1c) II) I recorded an Open Conclusion.
4	**CIRCUMSTANCES OF THE DEATH** Tamsin was raped as a schoolchild. In October 2017, she made a complaint to police that she had been raped again. (Of note, her adoptive parents, to whom a copy of this letter is being sent, were not aware of either incident until after her death.) Her GP reported her life having been turned upside down. It was intended that a SOLO would be appointed after the initial report but, in evidence, it was established that did not happen until the end of October, a delay of approximately a month. Tamsin was assessed by Outlook South West. It was felt she presented with too much risk and she was discharged from their service with a referral to the CMHT. After assessment by them (three months after the incident) it was felt she did not meet the statutory threshold and she was not taken on to caseload. At the time, there was a process for reviewing

	patient cases who fell between the two organisations but this had not been done by the time of her death. Tamsin was referred to the Women's Centre who conducted a needs assessment. She was advised there was a five-month wait for support. On 8/1/18, Tamsin fell over 20' from a railway bridge in St Austell on to the railway lines. The fall was unwitnessed and as there was no evidence of her intent in the form of a letter, email, text or similar, I concluded the evidence did not further or fully disclose the means whereby the cause of death arose and so returned an Open Conclusion. At inquest, I heard evidence from [redacted], general manager of Sexual Assault Referral Centre (SARC) of the importance of providing immediate care and support to rape survivors and the negative consequences that can occur where they feel their complaint is not being taken seriously, or there is a delay in the process. Tamsin's parents were of the view that, at the time she most needed support and assistance, she was largely left to fend for herself. I agreed with that view.
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. – I was informed by [redacted] that as of January this year, there were 600 open cases of rape or serious sexual assault. I was told additionally that there are over 20 vacancies for DCs to progress these complaints. One consequence was that it was taking over a month to achieve best evidence through video interview or otherwise. [redacted] agreed that the lack of available DCs meant that both the quality and amount of work that could be done were affected.
6	**ACTION SHOULD BE TAKEN** In my opinion action should be taken to prevent future deaths and I believe you [AND/OR your organisation] 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 10 July. 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: - ███ – parents - ███ – brother - SWAST - CPFT - BTP 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]** **[SIGNED BY CORONER]** **12.5.23**