*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], Secretary of State for Justice**
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 Dolamore who died on 9.1.18 at the age of 24. . 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 Sexual Offences Liaison Officer (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 patients 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 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	**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. – I heard at inquest that there has been considerable improvement and increases in funding for Sexual Assault Referral Centres (SARCs) across Devon & Cornwall to address events immediately after a rape or serious sexual assault. Funding, as I understand it, is provided by NHS England (copied in.) Where prosecutions are contemplated, a SOLO should then be appointed and effort is made to achieve best evidence by obtaining video evidence from the survivor as soon as possible. I heard that, as at January this year, there were 600 open rape and serious sexual assault cases with 20 vacancies at Detective Constable level to take them forward. This has been the subject of a separate PFD that has been sent to the Chief Constable and copied to the Police & Crime Commissioner. Where a matter progresses through the Criminal Justice system, I understand an ISVA will be offered. I believe funding for their provision has increased recently from £450K to £900K. I understand the 'ask' is estimated to be nearer £1.2M. This funding is provided through the Police & Crime Commissioner whom, I anticipate, will have a discretion about how their budget is allocated. If a survivor wants or needs therapy or support to aid with recovery,

	arrangements then become more complex. There are a number of charitable and voluntary organisations like The Women's Centre, Cornwall, First Light and CLEAR who provide commendable support, but their resources are limited and delays of six months or so are typical. The funding for these organisations is not guaranteed and all appear to have to compete in the same space for limited resource. There are some steps being taken towards the provision of a more joined-up approach through a peninsula sexual violence pathfinder [funded by NHSE] which brings together commissioners and services across Devon, Cornwall, Plymouth and Torbay to pilot new approaches to longer- term recovery support for those impacted by sexual violence. Locally, a joined- up service called Safer Futures [a partnership between First Light and Barnardos] has been commissioned by Safer Cornwall which includes Cornwall Council, the Integrated Care Board, NHSE and others. I am concerned that the provision of long-term therapy and recovery for the survivors of rape and sexual violence, which should be extended to include domestic abuse and child sexual abuse, needs to be formalised and provided with a guaranteed level of funding. You may wish to consider if this should be on a statutory basis. No one should have to wait half a year for help after being assaulted.
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. As I understand it, there is currently before Parliament a Victims & Prisoners Bill. This would appear to provide an obvious opportunity to introduce funding on a statutory basis or otherwise for those who need it.
7	**YOUR RESPONSE** You are under a duty to respond to this report within 56 days of the date of this report, namely by 20 July 2023. 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] – parents - [redacted] – brother

	- SWAST - CPFT - British Transport Police - [redacted], Police & Crime Commissioner - [redacted], Chief Executive, Cornwall Council - [redacted], Chief Executive, Integrated Care Board - Domestic Abuse Commissioners Office - NHS England 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] 22.5.23** **[SIGNED BY CORONER]**