	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO:** [redacted], Headteacher of The Jewish Free School Sent by post and e-mail

1	**CORONER** I am Mr P. A. Murphy, Area Coroner for the coroner area of the Northern District of Greater London
2	**CORONERS 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** Mia Janin was born on 7 June 2006. On 12 March 2021 Mia was found deceased at home aged 14 years old. On the 18 March 2021 an investigation was opened into her death and an inquest was opened on 31 March 2021. Following a lengthy police investigation a final inquest hearing concluded before me on 26 January 2024 as follows: "Mia Janin took her life while still a child and while still in the process of maturing into adulthood".

4	**CIRCUMSTANCES OF THE DEATH** Mia was last seen alive around 10pm on 11 March 2021 when saying goodnight to her parents in their family home. Mia was found deceased at home by her parents around 6.50am on 12 March 2021 suspended from from a ligature. Two undated notes in Mias handwrit ing were found on her bed on 12 March 2021 addressed to her family and friends, which explained that Mia had decided to end her life. Mias death was entirely unexpected by her family, friends and teachers. She had felt low self-esteem at times but had not been diagnosed with any mental illness nor presented a risk of taking her own life. Mia had close friends including at her secondary school but she also experienced bullying behaviour from some male students. Neither Mias family nor teachers was aware of that behaviour before her death. On 10 March 2021 Mia posted a video on social media asking two of these male students not to mock her and criticising their music and fashion. This video received a large number of hostile responses, which Mia found stressful. On the evening of 1 1 March 2021 Mia said to her parents that she had had a difficult week and asked to move to a different secondary school, which they agreed to explore. Toxicological examination confirmed the absence of any illicit substances in Mias system. The post-mortem examination found marks of self-harm (recent and old) of which Mias family was not aware. Mia is much missed by her loving family, friends and wider community who describe her as creative, kind, entrepreneurial and highly intelligent, amongst many other things. The current head teacher of Mias secondary school - the Jewish Free School (JFS) - gave evidence at the final inquest hearing concerning systemic changes introduced at JFS following Mias death. This included a co mplete overhaul of safeguarding practices, increased behaviour management, improved information, staff surveys and externally delivered sessions by charities including Norwood, Streetwise, Jewish Womens Aid and Keshet. Evidence provided by some JFS students after Mias death to the police and Ofsted described regular incidents of gender based bullying by some male JFS students of some female JFS students. Some of those child witnesses had not experienced a change in culture at JFS since Mias death and did not describe being consulted or surveyed about the changes introduced by JFS.

5	**CORONERS CONCERNS** The MATTERS OF CONCERN are as follows. - (1) Any ongoing gender based bullying at JFS gives rise to a concern that circumstances creating a risk of other deaths will occur, or will continue to exist, in the future; and (2) The initiatives introduced by JFS to address gender based bullying following Mias death do not appear to have gained the confidence of some JFS female students, which gives rise to a concern that circumstances creating a risk of other deaths will occur, or will continue to exist, in the future.
6	**ACTION SHOULD BE TAKEN** In my opinion action should be taken to prevent future deaths and I believe you and 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 18 April 2024. 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 via-email: [redacted] (via his solicitors) [redacted] (ibid) [redacted] (ibid) [redacted], Child Death Overview Panel, North Central London
9	D**ate** 22 February 2024