*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 Executive, Cornwall Council**
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 22/3/24, I concluded the inquest into the death of Michaela Hall. I recorded the cause of death as 1a) Stab Wound to the Right Eye Socket and Brain
4	**CIRCUMSTANCES OF THE DEATH** Michaela was a 49-year-old mother of two who lived at [redacted] Cornwall. In early 2018, she worked as a volunteer for an organisation providing support to prisoners to assist them in making a fresh start. She lost her role as a consequence of being unable to maintain professional boundaries. Later that year, she was employed by a charity providing support to vulnerable and at-risk individuals. That charity was not aware of the circumstances in which she lost her previous role. Michaela started a relationship with one of her clients, a prolific offender. He assaulted her on a number of occasions and was recalled to prison. Upon his release, their relationship continued as did the incidents of domestic violence. In April 2021, her partner pleaded guilty to two counts of common assault upon Michaela in respect of which he was sentenced to a Community Order. He was assessed as posing a medium risk of serious harm to Michaela and allocated to a Community Rehabilitation Company for offender management. On 31 May 2021, her partner stabbed Michaela through the eye. Acting upon information received, the police attended her home address but did not enter it. Michaela was found deceased the next day. Life was formally pronounced extinct at 22: 56 on 1 June 2021. Michaela's partner was subsequently convicted of her murder.

	I recorded the following conclusion. Michaela Hall was unlawfully killed. Shortcomings in a recruitment process meant she was employed in a role she was known to be temperamentally unsuitable for, given an inability to respect and maintain professional boundaries. Subsequently, a pre- sentence report was wrongly completed by an individual who was insufficiently qualified or experienced to undertake the task. The risk of serious harm Michaela's partner posed to her was wrongly assessed as medium rather than high. This meant her partner's management in the community was inappropriately allocated to a Community Rehabilitation Company rather than the National Probation Service. Had the shortcomings and errors not occurred, it is more likely than not that Michaela would not have died when she did.
5	**CORONER'S CONCERNS** During the course of these inquests, the evidence has 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. This was a particularly complex inquest with a wide range of agencies involved. I enclose a copy of my judgment which sets out the full position. In writing to you, I wish to draw your attention, in particular, the actions of Children and Adult Services. My findings of fact start from paragraph 260 of the judgment. The **MATTERS OF CONCERN** or the lessons to take from the inquest, in my view, are set out at paragraph 277 of the judgment. I set them out below for ease of reference. - do not delineate rigidly between adults and children but consider the family as a whole. Where appropriate and permitted in law, share information between services; - Record in writing a rationale for reaching a view that there are no eligible care and support needs; - Record in writing why a safeguarding (s42) enquiry may not be progressed on a statutory footing but on a non-statutory basis instead; - When considering a victim of domestic abuse, complete a needs assessment even when consent is not forthcoming; - If no eligible care and support needs are identified, take a step back and consider the exercise of discretion; - When relevant information is shared from a family member or health-related information is received, ensure this is acted upon and shared appropriately between Council services and wider agencies.

	- Be curious. There were multiple examples of potential mental impairment – a diagnosis of OCD, mentions of suicidality and depression, the Acton email, yet no health-related enquiries appear to have been undertaken.
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. You will be aware that a DHR is also with the Home Office for review and publication and that the SCP have taken a keen interest in proceedings.
7	**YOUR RESPONSE** You are under a duty to respond to this report within 56 days of the date of this report, namely by 25 May 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: - Michaela's parents and older son; - Michaela's younger son; - National Probation Service; - Kent Surrey and Sussex CRC; - [redacted]; - Police; - [redacted] I have also copied this report to the Domestic Abuse Commissioner. 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] 27.3.24** **[SIGNED BY CORONER]**