M. E. Voisin
His Majesty's Senior Coroner
Area of Avon

21st July 2025 REF:

	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO: Alexandra Homes Ltd**
1	**CORONER** I am M. E. Voisin HM Senior Coroner for Avon
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. http://www.legislation.gov.uk/ukpga/2009/25/schedule/5/paragraph/7 http://www.legislation.gov.uk/uksi/2013/1629/part/7/made
3	**INVESTIGATION and INQUEST** On 7th January 2015 I commenced an investigation into the death of Melissa Louise Mathieson. The investigation concluded at the end of the inquest on 18th July 2025. The medical cause of death was: 1a) Severe hypoxic ischaemic brain injury associated with an out-of-hospital cardiac arrest with features highly suggestive of neck compression The conclusion of the inquest was a short form with a narrative which read as follows: "Melissa died as a result of unlawful killing caused by both the act of strangulation and also due to the acts and omissions by the home entrusted with her care. The home failed Melissa in numerous ways: the resident who went on to strangle her should not have been placed in the same facility as Melissa, at all, based on his known risks. The decision was wrongly made to place him in the same facility with an ineffective care plan and risk assessment, with staff that were not trained on his level of risk, and managers who failed to act when concerns were highlighted by staff and Melissa. In addition, the placing authority knowing this residents risks should not have agreed the care plan and package being offered, furthermore they also failed to act when concerns were raised. With this resident's known risks he should not have been offered a placement at the home and the catalogue of failures resulting in his placement with no effective risk assessment in place resulted in the death of Melissa. "

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4	**CIRCUMSTANCES OF THE DEATH** Melissa was autistic, suffered with ADHD and had a diagnosis of Asperger's, she was 18yrs old and was vulnerable. She became a resident of Alexandra Homes in August 2014 along with another resident, called [redacted], who went on to murder her on 12th October 2014. [redacted] had undergone an assessment with a consultant child and adolescent psychiatrist, [redacted], who formed the opinion that he presented with a significantly high risk of future violence towards others, his violence also includes sexually harmful behaviour towards others including strangulation, the frequency and imminence of violence is also high, she said, that he should be supervised at all times. [redacted] had said that he wanted to kill somebody and have sex with their dead body. [redacted] was moving from a school where he had been supervised 24 hours a day on a 2:1 basis during the day and 1.5:1 at night. When at Alexandra Homes his care plan stated 1:1 but was not 24hrs a day and was not 1:1 care at all, in that at night there were 16 residents to 1 support staff and during the day he was allocated a support worker to do activities, but he could wonder around the home on his own unsupervised. Support workers, staff and Melissa raised concerns about [redacted]'s behaviour generally and specifically that Melissa was frightened of him. On 12th October at about 11.40pm, [redacted] and Melissa had already gone to their bedrooms, Jason was unsupervised, when staff heard a loud bang. One of them said ..." I ran up the stairs and opened the fire door, Melissa was on her back, her legs were slightly skew whiff. Her head was slightly to one side facing the stairs, I could see one eye which was open and there was a cut above it, I could see marks around her neck which were very red. She was fully clothed and she appeared dead..." Melissa was taken to the local hospital but died a few days later from her injuries.
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. – (1) the offer of placement and the level of supervision i.e. 1:1 was misleading, there was no clarification for example, 24hrs cover, 8hrs cover during the day only, or when carrying out activities or when outside the home only. (2) there was no formal induction period set for residents with formal weekly reviews (3) there was no formal review of the support plan and risk assessment especially during the induction period.

6	**ACTION SHOULD BE TAKEN** In my opinion action should be taken to prevent future deaths and I believe you Alexandra Homes Ltd 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 15th September 2025. 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] States of Guernsey Higford School 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	Signature M. E. Voisin HM Senior Coroner for Avon Dated 21st July 2025