Regulation 28: REPORT TO PREVENT FUTURE DEATHS

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

	REGULATION 28 REPORT TO PREVENT DEATHS **THIS REPORT IS BEING SENT TO:** **1 [redacted], Secretary of State for Education, Minister for Women and Equalities**
1	**CORONER** I am Darren STEWART OBE, HM Assistant Coroner for the coroner area of Hampshire, Portsmouth and Southampton
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 July 2019 I commenced an investigation into the death of Lucy-Anne DYSON aged 30. The investigation concluded at the end of the inquest on 18 December 2024. A Narrative Conclusion was recorded by the Jury.
4	**CIRCUMSTANCES OF THE DEATH** Narrative conclusion Lucy Ann Rushton was in a relationship with her husband for 9 years until they separated at the beginning of 2019. They were married in 2014, after which the relationship became dysfunctional and toxic. They had two children together and the father still maintained regular contact with the children and Ms. Rushton at the home. Whilst this was ongoing, the nature of the relationship between both parties was abusive and at times violent. The relationship made a material contribution to Lucy Rushton's death. On the 9th of September 2018 Lucy Rushton and her husband were spending a weekend away from their children at a hotel in Bournemouth. At 0300 am on the 9th September 2019 a 999 call was received by Police in relation to reports of an altercation at the hotel. Police responded and questioned Ms. Rushton in her hotel room, her husband having been asked to step outside the hotel room accompanied by a Police Officer. When questioned by Police Ms. Rushton denied any altercation having taken place or having been assaulted by her husband. CCTV evidence which existed at the time and showed a physical confrontation between Ms. Rushton and her husband was not secured by Police as part of their enquiries in relation to the incident. A Public Protection Notice (PPN) issued by Police following this incident was submitted 3 weeks after the event. At the time this was received by the home local authority for Ms. Rushton the PPN was not actioned due to it being confused as a duplicate of another, unrelated PPN concerning one of Ms. Rushton's children. The two children of Ms. Rushton and her husband attended a local primary school. In March 2019 one of the children of Ms. Rushton and her husband reported violence they witnessed between their parents to school staff. The school did not refer the matter following investigation to children's services. A further incident where similar comments were made

	again by Ms. Rushton's children was not referred to children's services when it should have been. Both incidents revealed a toxic relationship in existence between Ms. Rushton and the children's father. A referral to children's services was made on the 7th June 2019 following a safeguarding concern for the children due to Ms. Rushton's conduct. The referral was declined by children's services. On the 30th May 2019 a complaint was made to Police in relation to allegations concerning images taken of Ms. Rushton by her estranged husband on his mobile telephone. Following receipt of the complaint several lines of enquiry were not followed up by Police. When spoken to by Police Ms. Rushton confirmed that the images taken were of consensual activity between her and her husband. A formal risk assessment by way of a DASH Form was not completed and no Public Protection Notice in relation to the incident raised, the matter being closed following Ms. Rushton denying any offence having been committed when she was spoken to by Police. Lucy Rushton died on the 23rd June 2019 in the early hours of the morning as a result of a prolonged, severe and brutal attack with the cause of death being multiple blunt force injuries. Lucy Ann Rushton was unlawfully killed.
5	**CORONER'S CONCERNS** During the course of the investigation my inquiries revealed matters giving rise to concern. In my opinion there is a risk that future deaths could 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 lack of a national interface to enable reporting/communication between schools using safeguarding record keeping systems (e.g. CPOMS) and relevant agencies, including Police and Children's Services. 2. The lack of national guidance/standards means agencies with safeguarding duties for children are receiving referrals that either rely too heavily on the individual referrer's judgement about what should be included, or where no referral is made at all.
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 Wednesday, 29th October 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: The Family of Lucy Ann DYSON Née RUSHTON

	Hampshire Constabulary Dorset Police Hampshire County Council Anton Infants School Police Constable Harfield née Kness Police Constable Hanley Former Detective Sergeant Speck I have also sent it to Office for Standards in Education, Children's Services and Skills. who may find it useful or of interest. I am also under a duty to send a copy of your response to the Chief Coroner and all interested persons who in my opinion should receive it. I may also send a copy of your response to any person who I believe may find it useful or of interest. 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	**Dated: 03/09/2025** [redacted] **Darren STEWART** **HM Assistant Coroner for** **Hampshire, Portsmouth and Southampton**