ANNEX A

REGULATION 28: REPORT TO PREVENT FUTURE DEATHS (1)

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

	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO:** **1. Chief Executive, Rotherham Metropolitan Borough Council, Riverside House, Main St, Rotherham S60 1AE** **2. Secretary of State for Education, Department for Education, 20 Great Smith St, London SW1P 3BT**
1	**CORONER** I am Marilyn Whittle, Assistant Coroner, for the coroner area of South Yorkshire (West)
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 20 April 2023 I commenced an investigation into the death of Marcia Grant age 60 years old. The investigation concluded at the end of the inquest on 2 June. The cause of death was chest injuries. The inquest conclusion was that Marcia Grant died on 5 April 2023 on Hemper Lane in Sheffield after suffering significant injuries sustained from a collision with a motor vehicle driven by her foster child. The circumstances which led to this incident were contributed to by the failings of the Rotherham Metropolitan Borough Council to have appropriate systems and processes in place when placing foster children, including but not limited to the lack of accurate and complete documentation, failure to communicate risks and concerns appropriately, failure to conduct appropriate risk assessments and failing to safeguard those in their care.
4	**CIRCUMSTANCES OF THE DEATH** Mrs Grant was a foster carer for Rotherham Metropolitan Borough Council (RMBC). She was very skilled at fostering, well thought after and there were no concerns about her abilities to care for children. In March 2023 the Grant family were caring for Child Y, who was a complex child. They were under a 1 foster child category due to previous placement breakdowns. The last breakdown ended after the young person had entered a gang and weapons were found in the bedroom The plan was for Child Y to have a pre established relationship with anyone else coming into the home in future.

On 14th March Child x and sibling were transferred from Doncaster to RMBC. The child's social worker attended the transfer in conference and was aware of all information shared at that meeting. Child X had a long history of social care involvement across different Local Authority's. The Social Worker was made aware of youth caution for having possession of a knife. It was identified that Child X had at times talked about wanting to be part of gang culture and people were worried he was vulnerable to criminal exploitation.

The placement referral form, which should be completed by the Child's Social Worker, was sent to both the placements team and the fostering team for joint searches of in-house and independent fostering agencies to be undertaken. This did not contain all the relevant risks and information. Further forms contained more information regarding the risks but it could not be confirmed which form was being used for which searches.

Due to difficulties in finding a placement the placement team sent out a text message on 30 March to all in house foster carers, including the Grants who had been ruled out by the in-house team as an unsuitable match, for an emergency placement. Mrs Grant responded to offer a placement. The social worker who discussed the information included on the placement form with Mrs Grant would not have been able to discuss all the risks identified because they were not included on the form and they were not present at the transfer in conference. Mrs Grant's decision that she could provide Child X with a short term placement was made without her full knowledge of Child X's risks.

On 30 March the family's social worker received a call to discuss the placement. He was not given a great deal of information and not provided with Child X's risks. However, even without this information, he did not consider this to be a match. Had he known the other information about knives and gangs he would have categorically said that was not a match as there were too many risks.

There had been apprehension from all professionals in regard to placing Child X with the Grants and these conversations were reported to the Fostering Service Manager. The Head of Service in Children in Care approved the placement of Child X with the Grant family for 6 days over their category of approval. He had a verbal conversation and was not told about all the risks or reasons for the Grants previous breakdowns. He was told the Social Workers considered this to be a good match which was not correct. The Head of Service should have completed a decision making record form at the time. This form was completed by someone else on the 23 June 2023, some 3 months following the decision made.

On the 31 March there was a strategy meeting held about the absconding incident from the previous placement. The record of discussion states the that they were going to do that a safety plan. There was no record of any safety planning or any safety conversations.

The placement plan was not completed fully for Child X. Only a few parts were completed. It was accepted that this document should be completed and updated at a 72 hour meeting with relevant professionals and the foster carers. This did not take place.

	Residential homes were not included in the searches. The last resort would be an unregulated placement but as this was unlawful they would have had to have exhausted all other possible options. They did not consider a residential setting. Because of the lack of placements RMBC have opened more residential settings in the local area in order to place children who they cannot find foster carers for. The placement with the Grants continued to 4th April. On 4th April Mrs Grant received a visit from the Independent Revieing Officer who discussed the placement with Mrs Grant. The concerns raised by the IRO were relayed to the fostering team manager. Child X was removed from Mrs Grant's care on the morning of the 5th and taken out by a social worker for the day whilst they arranged another placement. Due to the mix up in dates there was a phone call on the morning of the 5th after Child X had left to ask Mrs Grant if she could keep Child X till the next day. This call was made despite the concerns that had been raised on the 4th by the IRO. Mrs Grant was then asked to keep Child X for a longer period. This further placement was not supported by others as the Fostering Service Manager emailed at back end of day when came to realise that potentially asking to go beyond the 6 working days. Sent email to say just want it noting not in agreement with that. Sadly on 5th April there was an incident where Child X took the Grants vehicle and when Mrs Grant positioned herself behind this to prevent him from leaving he reversed into her. She suffered significant chest injuries and was pronounced deceased at the scene.
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 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) Lack of placements. The lack of foster placements placed significant strain on the Local Authority to consider creative solutions to try and avoid an unauthorised placement. This led to an unsuitable placement being accepted. I was informed the shortage of placements is a both a local and a national issue and therefore both Rotherham Metropolitan Borough Council and the Minister for the Department for Education are asked to consider this concern. (2) Documentation and communication. Both the lack of documentation recording all the relevant risks, failure to complete forms and the lack of adequate communication of the risks in this matter led to a child being placed with a family where numerous individuals considered this was an inappropriate placement. Senior decision making was not based on all the appropriate information identifying there are inadequate systems and processes. (3) Risk Assessment. Evidence was heard about the risks posed by the Child but no evidence that the risk to the foster carers or the other

	child in their care had been considered or assessed. Again there was lack of documentation and no formal risk assessment document or collated risk profile for all individuals to allow proper consideration of risks.
6	**ACTION SHOULD BE TAKEN** In my opinion action should be taken to prevent future deaths and I believe you and your organisations 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 28 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 Marcia Grant 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	**03 September 2025 Marilyn Whittle HMAC**