REGULATION 28: REPORT TO PREVENT FUTURE DEATHS

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] Headmaster, Royal Hospital School, Holbrook, Ipswich, Suffolk** **2 [redacted], Secretary of State for Education, Minister for Women and Equalities**
1	**CORONER** I am Darren STEWART OBE, HM Area Coroner for the coroner area of Suffolk
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 17 April 2024 I commenced an investigation into the death of **Georgia Charlotte SCARFF** aged **16.** The investigation concluded at the end of the inquest on 10 October 2025. The conclusion of the inquest was: **Narrative Conclusion - Georgia Charlotte SCARFF was described by her family and friends as a caring, compassionate, thoughtful, kind and generous person who exuded warmth and a self-assured charisma. A private person whose company was uplifting, who deeply loved and cherished her family and who had a genuine desire to see the lives of those around her enhanced.** **At school, Georgia had been an accomplished and talented athlete who was known for her conscientiousness and commitment to her studies. During her GCSE year Georgia started to develop anxiety in relation to her academic performance, future options and how she would manage these. She confided her concerns to her mother who sought assistance from Georgia's school in January 2024. Georgia had not confided to anyone at her school about her concerns and had appeared to behave normally to both fellow students and staff throughout this time. Notwithstanding this, the school arranged for Georgia to receive counselling and at the time of her death she had undertaken three sessions with a Counsellor.** **Sunday, the 14th April 2024 was the last day of the Easter break and Georgia retired to bed that evening with the expectation being that she would return to school the following morning. She appeared to be normal and her family recalled her having had an enjoyable break and that evening seemed to be her usual self.** **At some point between 10.00 pm during the evening of the 14th and 01.20 am in the early morning of the 15th April 2024, Georgia left her home and proceeded to walk around Bury Saint Edmunds. She sent several messages to her mother and sister expressing thoughts of a concerning nature. At around 01.30 am on the 15th April 2024 Georgia stepped into the path of a lorry driving westbound on the A14 in the vicinity of Bury Saint Edmunds. The impact with the lorry caused**

	injuries which led to Georgia's immediate death. A subsequent Police investigation established that no defect with the lorry or conduct on the part of the driver were causative of Georgia's death. **At the time of her death, Georgia was experiencing anxiety associated with her ruminating about what she perceived to be concerns relating to her studies and future life choices. This led to Georgia acting impulsively in taking her own life by stepping into the path of a lorry and which caused her death.** The medical cause of death was confirmed as: **1a Severe Head Injury** **1b Road Traffic Collision**
4	**CIRCUMSTANCES OF THE DEATH** **Narrative Conclusion see part 4.**
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: **Royal Hospital School (RHS)** During the course of the Inquest the Court received evidence of the introduction and use of the Child Protection Online Management System (CPOMS) as a safeguarding system to ensure the safety of children attending RHS. In addition, the Court heard evidence of appropriate action being taken when concerns relating to Georgia were raised by her mother to school authorities. However, the Court also heard evidence that not all staff were familiar with or proficient in the use of CPOMS which, although not causative of Georgia's death, led to important information not being recorded in Georgia's CPOMS record. I am concerned that in another case the failure to record important safeguarding detail may result in a risk to life. **Department for Education (DfE)** During the course of the Inquest the Court heard evidence of national statutory guidance to schools in relation to safeguarding of children in the form of the DfE document 'Keeping children safe in education 2025, Statutory guidance for schools and colleges' dated September 2025. This statutory guidance includes reference to record keeping and information sharing. However, the Court also heard evidence that there is no single standard safeguarding information management tool for schools and colleges. Teachers moving between schools and colleges must familiarise themselves with different processes and tools depending on that used by an individual school or college. I am concerned that the absence of a single standard safeguarding information management tool for schools and colleges may result in a risk to life due to teachers being unfamiliar with different management tools and as a consequence important information relating to safeguarding not being recorded in children's safeguarding records.
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 April 1st, 2026. 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] **and to the Child Death Overview Panel.** I have also sent it to **Independent Schools Inspectorate** 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 other 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.
9	**Dated: 04/02/2026** [redacted] **Darren STEWART OBE** **HM Area Coroner for** **Suffolk**