HM Senior Coroner

Office of H. M. Coroner

Warwickshire Justice Centre
Newbold Terrace
Leamington Spa
Warwickshire,
CV32 4EL

REGULATION 28: REPORT TO PREVENT FUTURE DEATHS

	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO:** 1. **Warwickshire County Council, Children with Disabilities Team, Shire Hall, Market Place, Warwick, CV34 4RL** 2. **[redacted], Executive Director for Children and Young People, Warwickshire County Council, Shire Hall, Market Place, Warwick, CV34 4RL**
1	**CORONER** I am Deborah Sewell, Assistant Coroner for the coroner area of Coventry and Warwickshire.
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** I conducted an inquest into the death of Matilda Rose Davis otherwise known as Matilda Rose Southhall. The inquest concluded on the 20th March 2026. Matilda died on the 3rd October 2025 at her home address of [redacted] The medical cause of death was confirmed as 1a) Suspension by a ligature around the neck. I recorded a short-form conclusion of Suicide.
4	**CIRCUMSTANCES OF THE DEATH** On 3rd October 2025, Matilda was found deceased at her home in Stratford-upon-Avon. Earlier that day, Warwickshire Children's Social Care had conducted an urgent safeguarding visit following concerns raised by her estranged husband regarding her mental health and the welfare of their two children. During the visit, Matilda reported experiencing emotional and psychological strain arising from relationship conflict, financial pressures, and the ongoing divorce proceedings. She also described recent episodes of head-banging behaviour and confirmed aspects of her medical history, including discontinued antidepressant medication and a current

	prescription for diazepam. She stated that she intended to arrange a further GP appointment. Before concluding the visit, the attending social worker and the support worker noted that Matilda's demeanour was calm and that she expressed no suicidal ideation. Shortly after their departure, Matilda was found hanging by a ligature attached to the shower screen door frame in the upstairs bathroom. There was no evidence of forced entry. The emergency services attended, but Matilda was pronounced deceased at 16:26 hours on 3rd October 2025.
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. – Evidence heard during the inquest confirmed that suicide prevention training is not mandatory for frontline practitioners and staff within Warwickshire Children's Services. The social worker and support worker who visited Matilda had not received suicide prevention training, although such training was available within the organisation. In the absence of mandatory suicide prevention training, Matilda was not asked directly about suicidal ideation during the visit, where reference was made to suicidal thoughts within the referral context. It was also noted that she was not signposted to crisis support services at that time. The non-mandatory nature of suicide prevention training may give rise to variability in practice when practitioners are required to explore, record, or respond to indications of possible self harm or suicidal thoughts.
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 2nd June 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.

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8	**COPIES and PUBLICATION** I have sent a copy of my report to: - the Chief Coroner - the family of Matilda Davis via their representative. 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. She may send a copy of this report to any person who she 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	**7th April 2026** **Signed – D.Sewell, Assistant Coroner for Coventry and Warwickshire**