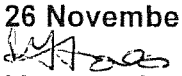
	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS THIS REPORT IS BEING SENT TO: 1. **Mr P Sims, Chief Constable, West Midlands Police**
1	**CORONER** I am Mrs Margaret Joy Jones assistant coroner for the coroner area of Staffordshire South
2	**CORONER'S LEGAL POWERS** I make this report under paragraph 7, 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 28 July 2014 I commenced an investigation into the death of Amanda Hawkins, 44 years of age. The investigation concluded at the end of the inquest on 25 November 2014. The conclusion of the inquest was Ia Unascertained with an open verdict.
4	**CIRCUMSTANCES OF THE DEATH** The deceased was 44 years of age and had a long standing diagnosis of schizophrenia. Due to closure of rehabilitation placements she had been obliged to move three times over three years each time resulting in a step-down in her level of care and a change of care co-ordinator. In June 2013 she transferred to 17 Moxley Court Wednesbury West Midlands, where she was free to come and go as she chose. Her history did not indicate any risk of suicide or self-harm but she did have a history of returning late to the accommodation and had done so on the 22nd May 2014. She was last seen at her accommodation at 09.00 hours on the 30th May 2014 and was reported missing by her mother at 21.51 hours on the 30th May 2014 to West Midlands Police. An ongoing search was failed to find her and her naked decomposed body was found by passers-by at 1820 hours on the 22nd July 2014 in a copse adjacent to a disused railway line off Meerash Lane Hammerwich close to where she had last been seen getting off a bus. Post mortem and toxicology examination found signs suggestive of hypothermia, quetiapine in the liver of uncertain significance and no obvious signs of trauma. The cause of death was unascertained.
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 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) When Amanda was reported missing she was classified as medium risk. No contact was made with her healthcare professionals. Had such contact been made earlier in the enquiry her risk profile may well have changed to high risk at an earlier point. This in turn may have led to a different approach in the search for her.
6	**ACTION SHOULD BE TAKEN** In my opinion action should be taken to prevent future deaths and I believe you and 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 21 January 2015. 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 Amanda Hawkins. 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	**26 November 2014**  Margaret Joy Jones Assistant Coroner Staffordshire (South)