Regulation 28: Prevention of Future Deaths report

Alexia Awenimi WALENKAKI (died 17.07.15)

	THIS REPORT IS BEING SENT TO: **1. Mr Will Tuckley** **Chief Executive** **Tower Hamlets Council** **Mulberry Place Town Hall** **PO Box 55739** **5 Clove Crescent** **London E14 2BG**
1	**CORONER** I am: Coroner ME Hassell Senior Coroner Inner North London St Pancras Coroner's Court Camley Street London N1C 4PP
2	**CORONER'S LEGAL POWERS** I make this report under the Coroners and Justice Act 2009, paragraph 7, Schedule 5, and The Coroners (Investigations) Regulations 2013, regulations 28 and 29.
3	**INVESTIGATION and INQUEST** On 28 July 2015, one of my assistant coroners, William Dolman, commenced an investigation into the death of Alexia Awenimi Walenkaki, aged nearly six years. Following a lengthy police investigation, my investigation concluded at the end of the inquest on 17 May 2018. My most sincere apologies to you and to Alexia's family that I am only now making this report a month later. The jury made a narrative determination, a copy of which I attach.
4	**CIRCUMSTANCES OF THE DEATH**

	Alexia fell from a rope suspended from a wooden post that collapsed when she was playing in a children's play area of Mile End Park on the afternoon of 17 July 2015. Her medical cause of death was: 1a traumatic head injury
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. The jury identified two causative factors in the equipment failure that resulted in Alexia's death: - inadvertent use of inappropriate wood; - organisational failure and lack of accountability for annual inspections. When one person was suspended and another went on maternity leave, there was no clear handover of responsibility for annual inspections. I fear that a lack clarity and continuity in terms of role demarcation and management structure may persist, particularly when staff move on. Whilst I heard that there have been changes at Tower Hamlets since Alexia's death, I am concerned that there is the potential for recurrence of the organisational failure identified by the jury.
6	**ACTION SHOULD BE TAKEN** In my opinion, action should be taken to prevent future deaths and I believe that you 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 20 August 2018. 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 following. • HHJ Mark Lucraft QC, the Chief Coroner of England & Wales • Tower Hamlets Safeguarding Children Board • [redacted], Alexia's mum 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 Senior Coroner, at the time of your response, about the release or the publication of your response by the Chief Coroner.
9	**DATE** **SIGNED BY SENIOR CORONER** 22.06.18