REGULATION 28: REPORT TO PREVENT FUTURE DEATHS (1)

	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO:** **Mr Tom Leverage** **Head Teacher** **Hewett School** **Cecil Road** **Norwich** **NR1 2PL**
1	**CORONER** I am JACQUELINE LAKE, senior coroner, for the coroner area of NORFOLK
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 18 May 2015 I commenced an investigation into the death of ISABEL ANN RICHARDSON, AGE 12 YEARS. The investigation concluded at the end of the inquest on 26 AUGUST 2015. The conclusion of the inquest was Medical Cause of Death: 1a) Hypoxic Brain Injury b) Cardiac Arrest c) Hanging and Conclusion: Isabel Richardson took her own life. Her intention at the time was not known.
4	**CIRCUMSTANCES OF THE DEATH** Isabel's mother died in 2010. Isabel started at Hewett High School in September 2014. In April 2015 Isabel was found to be self-harming by cutting her arms and legs. She told school staff and her father she was missing her mother and her step-mother. She was referred to Nelson's Journey Charity and a Counsellor for help. The school were telephoned by a parent of a concerned friend after seeing pictures posted on social media, informing them of Isabel self-harming. On the morning of Isabel's death the school were again telephoned by a parent about a post made by Isabel on social media indicating she may kill herself. The school contacted Isabel's father and indicated the appointment with Nelson's Journey would be chased up. Isabel had failed to attend one appointment with the Counsellor. It was not clear from the evidence why this was. An appointment was made with the Counsellor for the next day. It was not clear from the evidence Isabel had been made aware of this.
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) A Pastoral Team were in place at the School but it was not clear from the evidence as to their purpose, how they worked or whether they were trained in the role they were expected to perform;

	(2) It was not clear that the Pastoral system was robust or structured enough to deal with the problems that Isabel presented.
6	**ACTION SHOULD BE TAKEN** In my opinion action should be taken to prevent future deaths and I believe your organisation has 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 30 October 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 [redacted] and to the LOCAL SAFEGUARDING BOARD. I have also sent it to [redacted], Assistant Head of Democratic Services, Norfolk County Council, who may find it useful or of interest. 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	**28 August 2015** Ulake