	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO:** **The Chief Constable, South Yorkshire Police Headquarters, Carbrook House, 5 Carbrook Hall Road, Sheffield, S9 2EH**
1	**CORONER** I am David Urpeth, Senior Coroner, for the Coroner Area of South Yorkshire West
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 21.2.19, an investigation into the death of Emily Greene was commenced. The investigation concluded at the end of the inquest on 1.10.20. The conclusion of the inquest was a narrative conclusion, copy attached.
4	**CIRCUMSTANCES OF THE DEATH** On the 16.11.2018, Emily was found hanging from a tree in fields at the rear of Doghill, Shafton, Barnsley. The evidence was that Emily took her own life with the intention of so doing. Prior to her death, SYP had been involved investigating an allegation of sexual assault as well as dealing with the missing person's report.
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. – During the inquest, evidence showed:- 1. There was employment of an officer into a specialist sexual offences unit without the officer being given specialist training before he started work 2. There were deficiencies by the investigating officer and SYP in relation to the investigation into the allegation of sexual assault 3. There was lack of clarity around the BSARCS referral and its actioning 4. That Emily was never personally seen to sensitively explain the fact of and reasons why the police were not going to take the allegation any further. 5. There was (and I understand still is) lack of a suitable room for taking the victim video at Wombwell police station (due to a parent not being able to be accommodated) 6. There was mishandling of the missing person's report.
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 23rd December 2020. 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 to all Interested Persons:- • [redacted] (Mother), C/o [redacted], Howells LLP • [redacted] (Father) • [redacted] (Barnsley MBC) • Outwood Academy Shafton, Barnsley • Legal Services West Yorkshire Police • DC [redacted] C/o [redacted], Radcliffes Le Brasseur LLP • [redacted], IOPC 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	**6th October 2020** **David Urpeth, HM Senior Coroner**