Regulation 28: Prevention of Future Deaths report

Lily-Mai HURRELL SAINT GEORGE (died 02.02.18)

	THIS REPORT IS BEING SENT TO: **1. [redacted]** **Director, Children's Services** **Haringey Council** **Civic Centre** **255 High Road** **Wood Green** **London N22 8LE**
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 19 April 2018, I commenced an investigation into the death of Lily-Mai Hurrell Saint George, aged 10 weeks. Following a lengthy police investigation, the coronial investigation concluded at the end of the inquest on 8 February 2021. I made a determination at inquest that Lily-Mai had been unlawfully killed.
4	**CIRCUMSTANCES OF THE DEATH** Lilly-Mai was hurt by an adult with such force that she suffered 19 rib fractures, other broken bones, and a severe head injury from which she died. This took place on the afternoon/evening of Wednesday, 31 January 2018, while she was in the exclusive care of her parents.

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. Many healthcare and other professionals expressed the view that Lily-Mai should not be discharged into the unsupervised care of her parents, but Haringey Children's Services nevertheless facilitated that discharge from hospital on Thursday, 25 January 2018. Lily-Mai suffered her fatal injuries six days later. A legal gateway meeting took place on Wednesday, 31 January 2018 and the decision made that Lily-Mai should be placed in a residential unit, with both her parents if they would consent. Lily-Mai presented to the emergency services that evening, before such a placement was made. If you have not done so already, I encourage you to listen to the recording of the inquest so that you have a starting point for consideration of the actions and omissions of Haringey Children's Services.
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 12 April 2021. 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. • [redacted], mother of Lily-Mai • [redacted], father of Lily-Mai

	• Haringey Safeguarding Children Board • Haringey Child Death Overview Panel • Barnet Hospital • Care Quality Commission for England • HHJ Thomas Teague QC, Chief Coroner of England & Wales 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. 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.
9	**DATE** **SIGNED BY SENIOR CORONER** 10.02.21 *ME Hassell*