REGULATION 28: REPORT TO PREVENT FUTURE DEATHS (1)

*NOTE: This form is to be used **after** an inquest.*

	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO:** **1. A2Dominion of The Point, 37 North Wharf Road, London W2 1BD**
1	**CORONER** I am Samantha Marsh, Assistant Coroner, for the coroner area of Hampshire, Portsmouth and Southampton
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 the 27th January 2020, I commenced an investigation into the death of Kesia Blaine Waller, aged 17. The investigation concluded at the end of the inquest on 20th May 2021. The conclusion of the inquest was cause of death: 1(a) hypoxic brain injury and 1(b) hanging. Short form conclusions of Suicide.
4	**CIRCUMSTANCES OF THE DEATH** At around 21:09 on Monday 20th January 2020 Kesia Blaine Waller was discovered suspended from a ligature at her home address of [redacted] City Road, Winchester. She was taken to SGH where she was discovered to have a catastrophic hypoxic brain injury. Further treatment was deemed futile and life-sustaining treatment was withdrawn. Kesia sadly died in hospital on the 25th January 2020.
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 could occur unless action is taken. In the circumstances it is my statutory duty to report to you. The **MATTERS OF CONCERN** are as follows. – At Kesia's Inquest I heard that her place of residence, City Road in Winchester, was a residential housing unit for vulnerable young people aged 16-21. The facility meets a housing need only for the young persons placed there. It was found on the evidence that A2 Dominion employees did not have sufficient training or tools (i.e. implements) in place to prepare staff for the situation that they faced on the 20th January 2020 when they found Kesia hanging in her room, nor could they carry out any physical actions to assist her (i.e. cut her down). There appeared to be no prior appreciation of the risk(s) of self-harm, overdose or attempted suicide of residents, and so on discovering Kesia suspended in her room, the staff were inadequately prepared on multiple levels. (a) I heard that whilst there has been additional training for the staff on areas of risk such as self-harm, overdose and/or suicide, there have been no *physical changes* in terms of the provision of tools and implements that staff could use should they be confronted

	by a young person in distress and/or in need of life-saving attention. It appears to me that without multi-factorial changes there remains a real and significant risk that staff at the residential units will remain unable to take any immediate and potentially life-saving action. The only tools and equipment that remain supplied is a standard home-style first aid kit which is entirely ineffective if a young person has suspended themselves from a ligature. (b) Although additional training and courses have been added to both the induction training and on-going professional development of staff within the residential units similar to City Road, I remain concerned by the way in which key policies and training are communicated and implemented as this does not appear to have changed. It was clear from the evidence that updates to policies are emailed to employees with a request that the employee responds to the email to confirm receipt. This proved to be wholly ineffective as what appeared to be expected by the company was that the employee would read, digest and understand the policy, and confirm when he/she had done so. The employee on duty on the 20th January 2020 was clearly unfamiliar with the appropriate policies and had only confirmed that he had *received the email* (which appeared to be all that was required) and not that he had actually read, digested and understood the appropriate policy/ies; how to apply them in practice and what was reasonably expected of him. Although enhanced risk training is now place, it appears to me that without any enhanced diligence to ensure that policies are *actually read and understood* by those working face-to-face with the vulnerable young adults then the overall effectiveness of risk training and identification is severely flawed.
6	**ACTION SHOULD BE TAKEN** In my opinion action should be taken to prevent future deaths and I believe you 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 **26th July 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 Chief Coroner and to the following Interested Persons [redacted] Kesia's mother and to the LOCAL SAFEGUARDING BOARD (as the deceased was under 18). I have also sent it to Hampshire County Council and Ocean Safeguarding who may find it useful or of interest. 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	**1st June 2021** **Samantha Marsh**