	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO: OFSTED**
1	**CORONER** I am Dr James Adeley, Senior Coroner for **Lancashire & Blackburn with Darwen**
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. http://www.legislation.gov.uk/ukpga/2009/25/schedule/5/paragraph/7 http://www.legislation.gov.uk/uksi/2013/1629/part/7/made
3	**INVESTIGATION and INQUEST** On 4th June 2021 I commenced an investigation into the death of Oliver Brassington Weston, 17 years of age. The investigation concluded at the end of the inquest Thursday, 16 December 2021 . The conclusion of the inquest was: "*Oliver Brassington Weston died on the evening of Friday, 22 March 2019 at Cumbria View House by the* [redacted]. *Oliver's intentions were unclear as to* [redacted] *was applied but it was an impulsive act."*
4	**CIRCUMSTANCES OF THE DEATH** Oliver Brassington Weston was a looked after child placed in a home by Stockton Borough Council. On one and 14 February 2019 Oliver undertook [redacted]. On the evening of 22 March 2019 Oliver, in an impulsive act, [redacted].
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. – [BRIEF SUMMARY OF MATTERS OF CONCERN] (1) there was no documented evidence as to whether a monitoring or inspection visit was required following the death of a looked after child (2) the preplanning of the visit was deficient in that there was no indication that the four potential episodes of [redacted] known to OFSTED were a key line of enquiry (3) the safeguarding documentation, which was entirely relevant, was not considered by the inspector (4) other significant information indexed in the file, such as an annual psychological review, was not considered by the inspector (5) in almost every instance where OFSTED was critical of the Home it was either found to be based on insufficiency of enquiry, misinterpretation of the available evidence or drawing unsupportable conclusions from the available documentation resulting in OFSTED accepting that

	none of the breaches of the Regulations could be sustained against the Home. (6) on review by an inspector familiar with the home and a senior manager, a lack of critical appraisal failed to detect any of the deficiencies in the inspection. A critical appraisal might have been expected as the previous OFSTED rating of the Home was "outstanding" and no concerns were raised in the Regulation 44 reports (7) there is a discretion not to publish an OFSTED if there are "*exceptional circumstances*" which was relied upon by the senior manager in not publishing this report. OFSTED has provided no guidance to senior managers as to what constitutes "*exceptional circumstances*" which in this instance was taken to include the death of a child: in almost all other looked after child deaths, the death of the child was not sufficient to constitute "*exceptional circumstances*". A lack of guidance leaves senior managers to apply arbitrary criteria as to whether or not a report should be published (8) following an unannounced monitoring visit where the manager of the Home and the Responsible Individual were not present, no attempt was made to clarify any matters of concern with such individuals

6	**ACTION SHOULD BE TAKEN** In my opinion action should be taken to prevent future deaths and I believe 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 **1 March 2022**. 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 family and to the LOCAL SAFEGUARDING BOARD (where the deceased was under 18)]. 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	Dated 20 December 2021  Signature for **Lancashire & Blackburn with Darwen**