ANNEX A

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. Government Legal Department** **2. Worcestershire Health and Care NHS Trust** **3.**
1	**CORONER** I am Geraint Urias Williams, Senior Coroner, for the coroner area of Worcestershire
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 30th September 2014 I commenced an investigation into the death of Matthew Colin SARGENT then aged 31 years. The investigation concluded at the end of the inquest on 26 February 2016. The conclusion of the inquest was narrative (copy herewith) the medical cause of death being hanging .
4	**CIRCUMSTANCES OF THE DEATH** Mr Sargent was a serving prisoner as HMP Long Lartin. He died in his cell at sometime on 25th/26th September 2014. The jury concluded that he committed suicide but had concerns that there was an insufficiently systematic, correct, robust and clear imparting of historical and current information as between departments.
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) The Personal Officer of Mr Sargent appeared to have had little to do with him. It was suggested that there should regular meetings between Personal Officers and individual prisoners so that a more indepth knowledge of individual prisoners could be obtained ans shared. (2) There was a concern that historical information which was available to Officers and Healthcare staff was not reviewed when the prisoner first presented at the prison and it was suggested that it would be beneficial if there was an instruction that any member of staff dealing with a prisoner who had access to historical information should make some enquiry as to that historical information so as to inform them of both the present and past risks.

	(3) There was a concern that Healthcare staff were not made aware of prisoners who arrive with an ACCT history and it was suggested that Healthcare should be informed in all cases where a prisoner arrives at reception with an ACCT history so that there is a continued sharing of pertinant information. (4) There was a concern that the Prisoner Escort Record (hightlighting concerns and risks) was not supplied to the Healthcare Department and nurses at reception. It was suggested that this should be an imperative requirement for the further sharing of relevant information.
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, ie to consider whether there should be new or extended processes and protocols to ensure the sharing of relevant information based upon the concerns.
7	**YOUR RESPONSE** You are under a duty to respond to this report within 56 days of the date of this report, namely by 2nd June 2016, 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] (father of deceased). 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	**Signed** ..... **G U Williams** **7th day of April 2016** **H M Senior Coroner**