	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO:** **1. Mr Andrew Selous MP, Parliamentary Under Secretary of State for Prisons, Probation, Rehabilitation and Sentencing, Ministry of Justice.**
1	**CORONER** I am Dr Peter Dean, senior coroner for the coroner area of Suffolk
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 24th of May 2016, I concluded the inquest into the very sad death of STEVEN MARK TRUDGILL. The conclusion of the jury was Suicide.
4	**CIRCUMSTANCES OF THE DEATH** Steven Trudgill was found hanging in his cell at Her Majesty's Prison Highpoint on the 9th of January 2014. At the time of his death he was on an open ACCT (Assessment, Care in Custody and Teamwork) document. He had been remanded into custody at the age of 18 in November 2008, charged with arson with intent to endanger life, was convicted in March 2009 and received an indeterminate sentence for public protection, with a minimum period to serve of two years and two months before he could be considered for release. He had been moved from HMP Blundeston, which was due to close, to HMP Norwich on the 9th of December 2013, and then to HMP Highpoint on the 18th of December 2013.
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. – Steven Trudgill had a long and complex mental health history dating back to his childhood with a range of different treatments and different possible diagnoses. It was also clear that he had formed good and meaningful longstanding therapeutic relationships with mental health professionals in the recent past and, although he had expressed a wish not to go onto the mental health caseload in his new prison during his short time adjusting and settling in after his transfer to HMP Highpoint, he had been co-operative and compliant with treatment in the past (after a period of non compliance), and there was no reason to believe from the detailed picture that the evidence gave of Steven, that this could not be achievable again. He was clearly a young man with some insight and some complex mental health issues, and the firesetting offences and behaviour, longstanding in his case, for which he had been convicted was a form of behaviour, according to the forensic psychologists' report, that could, in some cases, have a significant underlying psychological component. The same detailed psychological report also identified five main factors which had been recognised to underlie deliberate fire setting behaviour, and found they could all be

	related to Steven's own history. It was also stated that there are currently no standardised treatment programmes for fire setters available within HM Prison Service, and a pilot that had been running was no longer accepting referrals. A Therapeutic Community, after further assessment of Steven's personality, was a suggested option for Steven's care and treatment, but this option, also contained in the same psychology report prepared for the probation service in advance of any future parole hearing, was never taken forward as Steven sadly died before any further parole hearing took place.
6	**ACTION SHOULD BE TAKEN** In my opinion action should be taken to prevent future deaths. It goes without saying that no criticism is implied or intended of Steven's indeterminate sentence itself, and there was also evidence of good quality mental health care having been provided to Steven previously while he was in prison. However, it was clear from evidence given that IPP's have now been stopped, and it is also likely to be the case that there are other potentially vulnerable prisoners like Steven who are still on IPP's within the prison system and at significant risk of continuing self harm after serving their tariff, finding themselves in a system where the Parole Board hearings that provide the only possible means by which they could be released are infrequent, only occurring two or three years. It is also the case that there are complex mental health needs which might actually be the reason for the continuing risk that keeps then in custody, as with Steven, yet the specific treatments are not available within the prison service, notwithstanding good care undoubtedly provided by good practitioners in difficult circumstances. To try to reduce the risk of future tragedies and fatalities like Steven's sad death occurring, I am writing to you as Prisons Minister to respectfully request that consideration now be given to assessing those prisoners currently still within the prison service on IPP's to see if they actually have mental health needs which would be better and more appropriately managed within the mental health service rather than the prison service, but within an appropriately secure unit. The aim of this would be to ensure that the appropriate level and form of mental healthcare can be provided to them in the most suitable environment in order to manage their underlying condition and reduce the risk of suicide, reduce future risk to the public and give care that might enable them to be more safely released in future, while still providing current public protection by virtue of the security of the unit.
7	**YOUR RESPONSE** You are under a duty to respond to this report within 56 days of the date of this report, namely by the 1st of August 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: The family and their legal representatives, Norfolk and Suffolk Foundation Mental Health Trust, Care UK, National Offender Management Service. Similarly, you are 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.
9	**Dr Peter Dean 6-6-16**