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:** **Her Majesty's Prison Service** **Care UK** **Essex Partnership University NHS Foundation Trust** **Bindmans Solicitors** **Phoenix Futures**
1	**CORONER** I am Caroline Beasley-Murray, senior coroner, for the coroner area of Essex
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 29 December 2016 I commenced an investigation into the death of Craig David Royce. The investigation concluded at the end of the inquest on 12 December 2017. The conclusion of the inquest was:- *Craig David Royce died as a result of an accident whereby he committed a deliberate act which unexpectedly and unintentionally led to his death. We the jury believe Mr Royce's risk of self-harm/suicide was not properly reviewed with appropriate precautions taken to manage the risk*
4	**CIRCUMSTANCES OF THE DEATH** Craig Royce, who was 46 years old at the time of his death, had a long history of mental health problems and he also suffered from epilepsy. On 15 August 2016 he was remanded in custody to HM Prison Chelmsford. On 26 October 2016 he was sentenced to 20 months imprisonment. During his time in custody he was subject to three ACCT processes and on the evening of 24 December 2016 he we found hanging in his cell. The medical cause of death was 1a) Hypoxic brain injury b) Suspension. After an incident of self-harm on 16 October 2016 he was placed on the second of these ACCTs and a note within the documentation reads "refer to MH". It would appear that no referral to the mental health service was made.
5	**<u>CORONER'S CONCERNS</u>** 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. – There is no form/template to deal with the situation of a prisoner who needs to be referred to the mental health service. Reliance upon the transfer of this vital information to Healthcare by means of a telephone conversation could be unreliable. A robust, simple documentary system is required for the communication of such important information, namely that a prisoner needs to be referred to mental health services for an assessment to be carried out by mental health services. This would be distinct from the TAG system which caters for a brief assessment to be relayed across.
6	**ACTION SHOULD BE TAKEN** In my opinion action should be taken to prevent future deaths and I believe you and your organisation have the power to take such action.
7	**YOUR RESPONSE** You are under a duty to respond to this report within 56 working days of the date of this report, namely by 12th March 2018. 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 – Bindmans, (solicitors for the family), Phoenix Futures 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	**20 December 2017** **HM Senior Caroline Beasley-Murray**