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 Clinical Services** **EPUT** **Farleys Solicitors** **Phoenix Futures**
1	**CORONER** I am Caroline Beasley-Murray, HM 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 20 March 2017 I commenced an investigation into the death of Timothy John Shaw. The investigation concluded at the end of the inquest on 30 January 2018. The conclusion of the inquest was:- ***Accidental death. The jury believe that with more resources and better communication further steps could possibly have been taken to manage Mr Shaw's risk of dying and may have prevented his death.***
4	**CIRCUMSTANCES OF THE DEATH** Timothy Shaw, who was 34 years old at the time of his death, had a long history of offending and substance abuse. On 9 January 2017 he was remanded in custody to HM Prison Chelmsford. On 30 June 2017 he was sentenced to a 6 year imprisonment. During his time in custody he was subject to three ACCT processes. It would appear that during his time in prison, he was using drugs including prescription medication and morphine patches. On 19 February, he was found under the influence and on the morning of 28 February, he was found collapsed in his cell. He was taken to Broomfield Hospital and he died there on 2 March 2017. It would appear that no referral to the mental health service was made.
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. – Continued……..

	• Healthcare staff seemed unclear as to how to fill in an Intelligence Report. There needs to be better communication between Healthcare staff and disciplinary staff as to the purpose of an Intelligence Report. Some criteria need to be developed and a system in place. An appropriate audit system needs to be in place. • The processes and systems for reducing access to illegal substances need to be improved and tightened up • The processes for referrals by both prisoners and staff to psychosocial services needs to be tightened up and improved. • The standard and accuracy of record keeping by both disciplinary and Healthcare staff needs to be improved.
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 days of the date of this report, namely by 3rd April 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- Solicitors for the family Phoenix Futures Government Legal Department CareUK EPUT 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	**15 February 2018** **Caroline Beasley-Murray**