REGULATION 28: REPORT TO PREVENT FUTURE DEATHS

	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO:** **1. The Chief Executive, RDaSH NHS Foundation Trust, Woodfield House, Tickhill Road Site, Balby, Doncaster, DN4 8QN**
1	**CORONER** I am Christopher P Dorries OBE, HM Senior Coroner for South Yorkshire (West)
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. (1) Where – (a) A senior coroner has been conducting an investigation under this Part into a person's death (b) Anything revealed by the investigation gives rise to a concern that circumstances creating a risk of other deaths will occur, or will continue to exist, in the future, and (c) In the coroner's opinion, action should be taken to prevent the occurrence or continuation of such circumstances, or to eliminate or reduce the risk of death created by such circumstances, the coroner must report the matter to a person who the coroner believes may have power to take such action. (2) A person to whom a senior coroner makes a report under this paragraph must give the senior coroner a written response to it. (3) A copy of a report under this paragraph, and of the response to it, must be sent to the Chief Coroner
	INVESTIGATION and INQUEST On 17th July 2015 I commenced an investigation into the death of Mr John Gogarty. The investigation had to await the conclusion of a Crown Court trial and then the preparation of reports from both the Probation Service and the Mental Health Trust but concluded following an inquest in April 2019 where the narrative conclusion set out that; *On the 13th July 2015 Mr Gogarty was unlawfully killed at his home by two persons who planned to steal £500 so that a drug debt might be paid. This was a particularly brutal attack in which Mr Gogarty was stabbed no less than 69 times.* *One of the offenders had previously been convicted of a similarly violent murder. He had been released on life licence on 9th December 2013 after serving eighteen years imprisonment. It is not the function of the inquest to comment upon the Parole Board's decision.* *The offender breached his licence conditions within a matter of weeks and was*

	inappropriately given an ACO final warning. This was an error. Whilst a warning may have been sufficient sanction at that time for the breach involved, the fact that it was issued as a final warning left the Probation Service nowhere to progress in the face of more serious breaches in May 2014. *The May 2014 breaches related to two positive tests for methadone, refusals in respect of urine testing and failure to attend a drug agency. Another final warning was issued, giving an inappropriate message to the offender. Nor was his status reviewed as it should have been.* *Whilst a decision on recall was subject to careful discussion by appropriate persons, the events of May 2014 as a whole amounted to a missed opportunity to take action which would, more likely than not, have safeguarded Mr Gogarty from an attack the following year.* *The offender progressed without further apparent breach and in November 2014 was allowed to leave the approved premises although still subject to weekly reporting for a further three months. At that time the Probation Service had no provision for drug testing in the community, which was a major omission, leaving the offender with much reduced scrutiny. This lack of an adequate system in place to provide effective monitoring was, on the balance of probabilities, a more than minimal contribution to the circumstances of Mr Gogarty's death.* *Over the ensuing months Offender 1 became less controlled and took to drink and more particularly drugs without this becoming apparent to his Offender Manager. His supervisory appointments fluctuated between fortnightly and monthly.* *In late 2014 the male offender developed a relationship with the female offender who had a significant history of drug abuse. Some of the circumstances became apparent to the Mental Health Trust assisting the female offender but an initial unsuccessful effort to liaise was not pursued when further information on identity became available only a short time later. At the least, this was a lost opportunity for meaningful communication, which would have led to valuable information being given to the Probation Service, there is a possibility, but not probability, that this would have altered the outcome.*
4	**CIRCUMSTANCES OF THE DEATH** The circumstances of the death are set out in some detail in the findings and conclusion previously supplied to the Interested Persons but a copy is attached hereto.

5	**CORONER'S CONCERNS** During the course of the investigation my enquiries revealed a matter giving rise to a concern. In my opinion there is a rick that future deaths may occur unless action is taken. In the circumstances it is my statutory duty to report to you. The **MATTER OF CONCERN** is as follows. – Your Trust was solely concerned with the care of [redacted]. During that care your patient was associating with [redacted] who had a very considerable history and was under the supervision of the National Probation Service following a sentence for murder. Although original efforts were made to contact the Probation Service to pass on information, these came to nothing because insufficient details about the male were known. However, within a relatively short time further information to identify this male became apparent but there was no further follow up with the Probation Service. No specific criticism is made of the member of staff involved at that time, it might very well be that many staff might have assumed that there was nothing to be gained. However, in reality, if the Probation Service had been aware of your patients background they would have at least had the opportunity to consider the conditions of the parole afresh, potentially putting in place further safeguards. It is respectfully suggested that the lesson here is that small pieces of information properly shared on an inter-agency basis might well add up to a bigger picture for other organisations.
6	**ACTION SHOULD BE TAKEN** In my opinion action should be taken to prevent future deaths and I believe you [AND/OR 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 20th August 2019. 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 family of Mr Gogarty. A copy will also be sent to National Probation Service. 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	**17th June 2019** **Professor Christopher Dorries OBE**