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. Rt. Hon Robert Buckland QC MP, Lord Chancellor and Secretary of State for Justice, House of Commons, London, SW1A 0AA 2. Rt. Hon Sajid Javid MP, Secretary of State for Health and Social Care, Department of Health and Social Care, 39 Victoria Street, London, SW1H 0EU 3. [redacted], Governor HMP Belmarsh, Western Way, Thamesmead,SE28 0EB 4. [redacted], Chief Executive, Oxleas, Pinewood House, Pinewood Place, Dartford, Kent, DA2 7WG
1	**CORONER** I am Dr Julian Morris, deputy coroner, for the coroner area of Inner London South
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. [HYPERLINKS]
3	**INVESTIGATION and INQUEST** On 25 November 2019 I commenced an investigation into the death of Stephen David COPE. The investigation concluded at the end of the inquest on 29 September 2021. The conclusion of the inquest was: 1a Suspension. The jury reached the following conclusions: Mr Cope voluntarily committed suicide which ended his life. We feel that he performed this act whilst conscious of what he was doing, and he intended to end his life. We do not consider there is enough evidence to suggest the closure of the ACCT on 04/09/2019 directly contributed to Mr Cope's death. Similarly, we consider a lack of information sharing between the health, mental health, care staff did not contribute to Mr Cope's death, staff were adequately trained to support Mr Cope and the response, by staff to Mr Cope's assault was appropriate and did not contribute to his death. The degree of risk of suicide identified in the risk assessment was documented and understood based on what Mr Cope communicated at the time.

4	**CIRCUMSTANCES OF THE DEATH** Mr Cope died on 18th November 2019 at 17:48 in Belmarsh prison in his own cell block by suspension. Mr Cope was remanded to HMP Pentonville in relation to an offence of attempted murder. He was placed on an ACCT on 12th August due to suicidal thoughts - he was very stressed about his trail and missing his daughter. He then moved to HMP Belmarsh on 2nd September and referred to mental health team, substance misuse, counselling and general practitioner on 3rd September. Mr Cope was taken off the ACCT on 4th Sept and put on Sertraline. On 18th November 2019 Mr Cope remained in his cell whilst his inmates attended class and at 16:45 an officer found Mr Cope hanging from a ligature on the top bunk.
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. – (1) The transfer and review of prisoners on an ACCT. I am concerned in relation to the ability of any Prison to close an ACCT, with the attendance of 2 individuals (a prison and health care staff), after a short period of time on a newly transferred inmate (i.e. to a new prison) before anyone has had the time to review and assess him or her. For ACCTs created on current inmates within an establishment, who are known to staff, I do not see that as an issue, they would already have an existing knowledge and relationship and indeed would have been the originator of the ACCT in any event. However, for new prisoners, who have arrived from another prison establishment with an open ACCT on their record, I consider the ability to remove that individual from the ACCT, within a short period of time, does raise issues in respect of the knowledge and understanding of that individual and the ability of various agencies, within the prison, to have had time to review and communicate between themselves, about that individual. The provision of in effect 2 'no' answers by a prisoner, is a potentially easy way of coming off an ACCT, which is there for their support and well-being, and I would suggest, given to easy manipulation I raise the issue as to whether there should be, for example, a set review period (e.g. 7 days) which allows time for the support services to meet with and interview the transferred inmate, interact, and then make a decision about and with the newly transferred prisoner on the ACCT before such an ACCT is closed.
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.

7	**YOUR RESPONSE** You are under a duty to respond to this report within 56 days of the date of this report,
	namely by Monday 29th November 2021. 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 Cope Family HMP Belmarsh Oxleas NHS Trust I am also under a duty to send a copy of your response to the Chief Coroner and all interested persons who in my opinion should receive it. I may also send a copy of your response to any other person who I believe may find it useful or of interest. 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	**30/9/2021** ***Dr Julian Morris***