Regulation 28: REPORT TO PREVENT FUTURE DEATHS

NOTE: This form is to be used **after** an inquest.

	REGULATION 28 REPORT TO PREVENT DEATHS **THIS REPORT IS BEING SENT TO:** **1 The Honourable Victoria Atkins QC MP, Minister of State (Ministry of Justice) for Prisons and Probation**
1	**CORONER** I am Miss Laurinda Bower, Her Majesty's Assistant Coroner for the coroner area of Nottingham City and Nottinghamshire
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 21 May 2019, I commenced an investigation into the death of Terance Alfred RADFORD, aged 87 years. The investigation concluded at the end of the inquest on 14 January 2022. The conclusion of the inquest was that: At around 09.30 hours on 19 April 2019, Mr Terance Alfred Radford was stood waiting at the bus stop on Worcester Avenue, Mansfield Woodhouse, Nottinghamshire, when he was struck by a car, driven at speed directly into collision with him, by a male driver who had taken the car from its owner shortly before the said collision. Mr Radford died at the scene as a result of his injuries. Mr Radford was unlawfully killed.
4	**CIRCUMSTANCES OF THE DEATH (restricted to the circumstances relevant to this report. A full note of the findings and conclusion has been shared with this report)** On 20 April 2020, a jury sitting at Nottingham Crown Court, convicted [redacted] of the manslaughter of Terry. The inquest learned that [redacted] had been released from HMP Ranby, Nottinghamshire, less than 24 hours prior to Mr Radford's death. His release from prison was contrary to the national Home Detention Curfew Policy Framework, because he was, at the material time, awaiting the resolution of an Independent Prison Adjudication, dated 13 April 2019. A decision to downgrade the level of adjudication from independent to internal, made by three Governors on 15 April 2019, not including the original decision-making Governor, had no basis in prison policy or procedure, and was driven by a desire to circumvent the terms of postponement set out within the Home Detention Curfew policy framework, in order to release [redacted] from custody on 18 April 2019, rather than post-29 April 2019, when the Independent Adjudication was due to be heard. This decision provided [redacted] with the opportunity to bring about the death of Mr Radford in the circumstances described above. But for the decision to release [redacted] on Home

	Dentention Curfew, Mr Radford would not have died when he did and in the manner he did. At the time of [redacted] release from prison, he was considered by prison staff to pose a risk of causing harm to others, such that he could not be safely managed on the general residential block, and instead had been detained in the segregation unit since 29 March 2019. While in the segregation unit, he had continued to engage in behaviour that placed others at risk of harm, including fire setting and assault. At the material time, the Home Detention Curfew Policy Framework did not expressly prohibit prisoners from being released early from their sentence on home detention curfew directly from the segregation unit or on account of their behaviour while in custody. The Probation Support Officer had not completed a pre-release risk assessment, and had not considered any risks associated with his release above and beyond the suitability of the proposed release address. There was no information sharing between prison, mental health services and probation staff, that considered [redacted] risk of harm to others on release, in the context of a prisoner who was known to have stopped taking his mental health medication and had disengaged from mental health services, who required isolation in the segregation unit due to his repeated violent outbursts, and who had displayed unusual and bizarre behaviour in the 48 hours prior to his release.
5	**CORONER'S CONCERNS** During the course of the investigation my inquiries 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: (brief summary of matters of concern) 1. The national Home Detention Curfew Policy Framework permits **the release of eligible prisoners directly from the Prison's segregation unit**, in circumstances where the prisoner has been placed in the segregation unit because the elevated risk of harm they pose to staff and other prisoners cannot be safely managed within the general prison population. The public may rightly be concerned that prisoners deemed 'too risky' to reside within the general prison population; with its strict curfews and regime, use of locked cells, and trained prison personnel with protective gear, can still be released early from their sentence under the terms of the Policy. 2. The national Home Detention Curfew Policy does not expressly require **consideration or assessment of the prisoner's risk of harm to others, beyond the suitability of the proposed release address**. If a broader assessment of risk of harm to others is anticipated by the Policy, there is no guidance on who should complete the assessment (singular or multi-agency input), when it should be completed, and what factors ought to be considered as part of that assessment. 3. The national Home Detention Curfew Policy contains no **framework for multi-agency information sharing** with regards to the assessment and management of risk for those deemed eligible for early release under the terms of the Policy.
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 March 15, 2022. 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; **Mr Radford's family** **HM Prison and Probation Service** **Nottinghamshire Healthcare NHS Foundation Trust (Prison mental health care providers)** **Derbyshire Healthcare NHS Foundation Trust** **The Chief Constable of Nottinghamshire Police** **The Chief Constable of Derbyshire Police** **The victims of [redacted] conduct on 19 April 2019 (who have expressed an interest in receiving this report)** I have also sent it to **The Governor of HMP Ranby** **The Independent Monitoring Board for HMP Ranby** **Prison and Probation Ombudsman** **HM Inspectorate of Probation, Chief Inspector, [redacted]** **Care Quality Commission** who may find it useful or of interest. 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 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 by the Chief Coroner.
9	**Dated: 18 January 2022** **Miss Laurinda Bower** **HM Assistant Coroner**