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** [redacted]
1	**CORONER** I am Rosamund RHODES-KEMP, Area Coroner for the coroner area of Hampshire, Portsmouth and Southampton
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 14 May 2020 I commenced an investigation into the death of Daniel-John VARNDELL aged 30. The investigation concluded at the end of the inquest on 24 November 2022. The conclusion of the inquest was that: On 4th January 2019 Daniel Varndell, aged 30, was sentenced to 18 months' imprisonment for various offences. He was sentenced to a further 36 weeks on 29th August 2019 to run consecutively and another 6 weeks on 16th April 2020 to run concurrently. He was considered to be a high risk of serious harm to the public and Prison and hospital staff, adults and children by the National Probation Service and by others to himself largely due to his drug use and mental health which had historically included a diagnosis of Schizophrenia more recently Personality Disorder therefore his release was the subject of detailed multi-agency planning including a Trigger plan, Mental Health Support and the creation of a list of those known to be at risk upon Daniel's release. His release took place on 7th May 2020 and was to be on licence with conditions until 27th May then on post Licence supervision until 2021. He was to be taken to Dickson House, an Approved Premise, at least for his initial licence period. Although a Licence Condition was removed concerning regular appointments with Mental Health Practitioners shortly before Daniel's release once at Dickson House, he was contacted by a clinical psychologist on 7th May to discuss his needs, but she was unable to reach him and arranged to call him again on 11th May. Staff engaged with him, he struggled to abide by the Dickson House and Covid 19 rules but initially he seemed to be reasonably settled in the Approved Premises where staff instituted regular welfare checks to monitor his wellbeing. On evening of the 10th of May 2020 there was an altercation with another resident. Staff raised the alarm and he absconded. There is a discrepancy in timings and a gap of about 10 minutes from when the AP staff say the incident began and they activated their personal alarm and when the Alarm company received an Alarm Notification which cannot be accounted for and remains unresolved. Police were alerted, responded swiftly but by the time they arrived he had already left. An initial search proved fruitless ass did the Recall process as he had gone to an address not on the Trigger list and with which he had no previous connection.
4	**CIRCUMSTANCES OF THE DEATH**

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) The MAPPA meeting (consisting of over 20 professionals due to the complexity of the release planning) decided that various Conditions should apply to Daniel-John Varndell's Licence as he posed such a high risk to himself and others. One of these was: " Attend all appointments arranged for him with a psychiatrist/psychologist/medical practitioner and co-operate fully with any care or treatment they recommend" This was for use with a specific named practitioner, who must have agreed to treat him and he should have consented to this prior to the condition being added so unless something had been set up prior to release this condition may not have been suitable. The condition was unilaterally removed by a probation officer possibly because consent was not in place or for another reason. The point is there was no discussion with MAPPA professionals nor any mental health practitioner prior to removal notwithstanding that the Chair of MAPPA indicated that the conditions were appropriate and necessary. Whilst this may not have affected the outcome in the present sad case such unilateral removal of a Licence Condition could result in a future death.
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 January 24, 2023. 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 [redacted] I have also sent it to [redacted] 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: 29/11/2022**  **Rosamund RHODES-KEMP** **Area Coroner for** **Hampshire, Portsmouth and Southampton**