REGULATION 28: REPORT TO PREVENT FUTURE DEATHS

	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO:** **NHS England, PO Box 16738, Redditch, B97 9PT**
1	**CORONER** I am Nicholas Leslie Rheinberg, assistant coroner for the coroner's area of Exeter and Devon
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 1st April 2020 an inquest was opened into the death of Samuel Thomas Jordan aged 25 years. The investigation concluded at the end of the inquest on 30th January 2024. The conclusion of the inquest jury was that Samuel Thomas Jordan died as a result of suspension by a ligature, his death being by suicide whilst suffering from mental illness.
4	**CIRCUMSTANCES OF THE DEATH** Samuel Thomas Jordan was sentenced to 8 weeks' imprisonment at HMP Exeter. This was his first time in prison. He suffered from mental illness which whilst in prison manifested itself in bizarre behaviour and an act of self-harm. Following fights with a cell mate on 26th March 2020 he was placed in a single occupancy cell where he was found hanging about 4 ½ hours later
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. – During the four months before his imprisonment, Samuel Jordan had been receiving treatment for severe anxiety while registered as a temporary patient with a medical practice in Launceston, Cornwall. Samuel had come to Cornwall from his home in Whitchurch, Hampshire where he was registered with another GP practice. On entering HMP Exeter, the prison Healthcare obtained a summary of Samuel's GP records from Hampshire via the NHS spine. The records from the Launceston practice were not sent to the prison since the NHS spine only operates to transmit records from the permanent GP practice and not a practice consulted on a temporary basis. As a result, Exeter Prison Healthcare was unaware of Samuel's mental health issues immediately before coming to Prison and was unaware of a current medication prescription lack of which the jury found contributed to Samuel's death. The inquest heard that prisoners coming to prison frequently were nomadic and frequently had registered with GP practices on a temporary basis with the records from such practices not coming to the notice of prison healthcare as such records are not

	accessible through the NHS spine. Lack of access through the NHS Spine to the records of the practice where Samuel was registered as a temporary patient was, the jury found, a contributory factor in Samuel's death.
6	**ACTION SHOULD BE TAKEN** In my opinion action should be taken to prevent future deaths and I believe your organisation has 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 2nd April 2024. 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 namely the Samuel Thomas Jordan's family, Oxleas NHS Foundation Trust, Practice Plus Group, Cornwall Partnership NHS Trust, Devon Partnership NHS Trust and Ministry of Justice. 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	**Dated 2nd February 2024 SIGNED *N.L.Rheinberg*** **Assistant Coroner**