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] **2**
1	**CORONER** I am Nick ARMSTRONG KC, Assistant Coroner for the coroner area of West Sussex, Brighton and Hove
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 03 February 2023 I commenced an investigation into the death of Francis Ian WILLIAMS aged 43. The investigation concluded at the end of the inquest on 05 March 2024. The conclusion of the inquest was that: Francis Williams was the subject of a sentence of imprisonment for public protection ("IPP"), imposed in 2006. He had always struggled with that sentence, believing that he would never be free of it. He had been released in 2009 and by 2018 had had the supervision element of the sentence removed. In 2020, however, and in part following problems experiencing during the Covid lockdown, supervision was reinstated and in March 2021 Francis was recalled to prison. Francis was re-released in April 2022 and initially seemed to be progressing well once again. In late 2022 and early 2023, however, Francis was struggling once more, and in particular, with alcohol. He had lost one set of specialist accommodation in November 2022. He then had a warning from the new one on 9 January 2023. On 27 January 2023 Francis was finally evicted from that accommodation after he had been drunk the night before and had behaved inappropriately including towards female staff. The probation service sought urgently to find alternative accommodation but without success. They started to take steps to recall him to prison. Francis realised that is what was likely to happen, and he told his probation officer he was going to kill himself [redacted]. She made a warning call to police. On 28 January 2023, however, Francis was found by workmen in a tent in the sunken gardens in Bognor Regis. He had died of a heroin overdose. He was 43 years old.
4	**CIRCUMSTANCES OF THE DEATH** Francis Williams was the subject of a sentence of imprisonment for public protection ("IPP"), imposed in 2006. He had always struggled with that sentence, believing that he would never be free of it. He had been released in 2009 and by 2018 had had the supervision element of the sentence removed. In 2020, however, and in part following problems experiencing during the Covid lockdown, supervision was reinstated and in March 2021 Francis was recalled to prison. Francis was re-released in April 2022 and initially seemed to be progressing well once

	again. In late 2022 and early 2023, however, Francis was struggling once more, and in particular, with alcohol. He had lost one set of specialist accommodation in November 2022. He then had a warning from the new one on 9 January 2023. On 27 January 2023 Francis was finally evicted from that accommodation after he had been drunk the night before and had behaved inappropriately including towards female staff. The probation service sought urgently to find alternative accommodation but without success. They started to take steps to recall him to prison. Francis realised that is what was likely to happen, and he told his probation officer he was going to kill himself [redacted]. She made a warning call to police. On 28 January 2023, however, Francis was found by workmen in a tent in the sunken gardens in Bognor Regis. He had died of a heroin overdose. He was 43 years old.
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) My investigation reveals two relevant concerns: 1. That probation officers need to understand, and be constantly alert to, the risk of suicide/self-harm in IPP offenders. It is clear from Mr Williams' case, but also from other cases and other evidence, that this cohort often experiences a particular kind of despair. That is fuelled in part by the particular sense of unfairness that they feel about being on an IPP at all, now the sentence has been abolished and all agree that IPP sentences were a terrible idea. The other factor is the absence of hope of ever getting off it. 2. Linked to that second point, it is crucial that probation officers are also fully versed in the processes for suspending parole licence supervision and then cancelling it altogether. One of the real tragedies of Mr Williams' case is that in 2019 he had been free for ten years, so he should have been referred for licence cancellation. It did not happen, and it is not clear why, but it may have been because no-one was actively looking at him given that his supervision had been suspended. In any event, the referral system did not work and Mr Williams was never referred, at any stage, for cancellation. Mr Williams was then overtaken by lockdown and related matters in 2020, which pulled the rug on his business and other protective factors, and he then returned to supervision and ultimately recall to prison. Following release in 2022 he was still not referred, and even at the end of that year - which I note was now after the amendments to s.31A of the Crime (Sentences) Act 1997 and the introduction of an entitlement to automatic referral to the Parole Board for cancellation – no referral had been made. By then, of course, Mr Williams might have found cancellation much more difficult. However, it is noteworthy that even with those well publicised changes, which Mr Williams had heard about, his probation officer seemed to be struggling to find out how the process worked (entries in the probation records in December 2022 confirm). Again, the point is that there is a particular kind of despair among the IPP cohort. The main safeguard is the facility for getting off that, or at least giving these men hope that they may be able to get off it. Mr Williams and his probation officer were struggling to find out how to access even that limited (and automatic) safeguard. It was very shortly after that (within a month or so) that he took his life. The jury was clear that the fact of the IPP caused his state of mind and so caused his death. It seems to me that these two concerns at least give rise to a training need. There may be more. But I consider that action should be taken.

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 May 22, 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 [redacted] I have also sent it to The Chief Coroner 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: 27/03/2024** **Nick ARMSTRONG KC** **Assistant Coroner for** **West Sussex, Brighton and Hove**