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 Chief Coroners Office** **2** [redacted] **3** **4**
1	**CORONER** I am Rosamund RHODES-KEMP, HM 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 7th March 2020 an investigation commenced into the death of Craig Steadman aged 32 years. The investigation concluded at the end of the inquest on 1st August 2024. The conclusion of the Jury at Inquest was Medical Cause of death 1a.Ligature Suspension and 2.Mental Illness NARRATIVE CONCLUSION Mr Steadman died by suicide at 01:25 on the 27/02/2022 in cell D36 at 3, West Hill, Romsey Road, Winchester. A probable contributing factor was the extended lock up due to the covid regime and staff shortages meaning that Mr Steadman had not left his cell at all on 26/02/2022. A possible contributing factor was the inadequate implementation of the ACCT process on 26/02/2022
4	**CIRCUMSTANCES OF THE DEATH** In January 2020 Craig Steadman was released from Custody on Licence but a week later he breached a condition and was remanded back to HMP Winchester on 13th January. He had Diabetes and a mental health history, was on a weekly anti psychotic injection plus a history of multiple self harming incidents including overdosing on [redacted]. After being assessed as suitable to hold his own medication he overdosed on [redacted] on 17th January 2020 and was placed on an ACCT which was closed again on 18th January. He struggled with the Covid Lock Down restrictions and lack of contact with his family. On 26th February he self harmed, cutting himself [redacted], and the ACCT was reopened. At 00:44 he was found suspended by a ligature [redacted]. CPR by staff then paramedics proved futile and he was sadly pronounced deceased at 01:25 on 27th February 2020.
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) There were several investigations into Craig Steadman's death including a post incident review by HMP Winchester, the PPO,and the prison healthcare provider. Various recommendations flowed from the above. However upon questioning of various members of staff called to give evidence at the Inquest it became clear that several of them were not aware of the findings of the investigations nor the recommendations. The reports had not been shared with staff directly involved with Craig during his recent time in custody. It is not possible for learning to be fully disseminated and acted upon if there is no process for sharing the findings of those organisations tasked with investigating deaths in custody and discussing these with the relevant Prison/Healthcare staff.
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 **October 07, 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] **Government Legal Department** **Practice Plus Group** I have also sent it to **Chief Coroners Office** 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: 12/08/2024**  **Rosamund RHODES-KEMP** **HM Area Coroner for** **Hampshire, Portsmouth and Southampton**