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 Probation Service**
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 14 March 2023 I commenced an investigation into the death of Lee Spencer PURKIS aged 54. The investigation concluded at the end of the inquest on 25 June 2024. The conclusion of the inquest was that: Lee Purkis was aged 54 at the time of his death. He was found in a state of advanced decomposition on the floor of his home on 9 March 2023, having been there for up to two months. The cause is unascertainable; he not been seen since 6.1.23.
4	**CIRCUMSTANCES OF THE DEATH** Lee Purkis was aged 54 at the time of his death. He was found in a state of advanced decomposition on the floor of his home on 9 March 2023, having been there for up to two months. The cause is unascertainable; he not been seen since 6.1.23.
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 concern here is that Lee Purkis had been, in the period leading up to his death, the subject of a mental health treatment requirement (MHTR) imposed by the Crown Court as part of a community order, but the Trust that ended up treating him were not aware of it, and discharged him from its care without learning about it. There is no evidence that it made any difference in this case but that is because of the particular (and unfortunate) circumstances of how long it took to find Mr Purkis and the corresponding absence of evidence about how he died. There is, however, a real risk that it might make a difference in another case. This order was handed down by a sympathetic Crown Court judge, supported by probation in the pre-sentence report, and it seems to have been a potentially creative solution for a complex man. The use of MHTRs is, it seems to me on the evidence, to be encouraged, but that objective will be undermined if they are not understood and administered properly and so people don't see them working. In Mr Purkis's case, the particular problem appears to have occurred because the Trust that agreed the order (a

	requirement of it being imposed in the first place) then transferred the care because the accommodation area changed. That is not unusual, but the relevant Trust then failed to transfer or inform the receiving Trust of the fact of the MHTR and what it required. This means that it was, of course, a Trust error, but I am sending this report to probation because the evidence suggests that it is probation that should have the oversight, and should be ensuring all involved in the administration of the requirement are aware of it. I therefore consider that there is a risk associated with these circumstances, and that action should be taken, such as reminding or ensuring that probation officers keep an eye on MHTRs when they have them, and ensure the other services do so too. There are not many of them; there probably should be more; but again, that means ensuring the ones that there are get used properly.
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 September 25, 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] **Probation Services (Crawley)** **Legal Services SPFT** 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: 01/08/2024**  **Nick ARMSTRONG KC** **Assistant Coroner for** **West Sussex, Brighton and Hove**