Coroner Service
West Sussex, Brighton & Hove

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** **2 Steps2Recovery**
1	**CORONER** I am Nick ARMSTRONG, 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 01 June 2023 I commenced an investigation into the death of Kirsten HOCKING aged 31. The investigation concluded at the end of the inquest on 08 November 2024. The conclusion of the inquest was that: Kirsten Hocking was 31 years old when she died as a result of a heroin overdose. She had been released from prison on 19 May 2023, and found in a public toilet in Worthing on 20 May 2023. She was taken to Worthing Hospital where she died at 16:45 on 24 May 2023.
4	**CIRCUMSTANCES OF THE DEATH** Kirsten Hocking was 31 years old when she died as a result of a heroin overdose. She had been released from prison on 19 May 2023, and found in a public toilet in Worthing on 20 May 2023. She was taken to Worthing Hospital where she died at 16:45 on 24 May 2023.
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) Please also refer to the findings of fact, which accompany this report and set out the circumstances of Kirsten Hocking's death and Box 4 of the Record of Inquest (the narrative conclusion). I have three concerns about future risks, two of which are for the Probation Service (and/or the Ministry of Justice ("MOJ"). The other is for the charity Steps to Recovery ("S2R"): TO THE PROBATION SERVICE/MOJ: Concern (1) is that there was and remains a real lack of specialist rehabilitation for women, and in particular, women who represent only a low or medium risk of harm to others, but a high risk of self-harm. This cohort are for the most part shut out from Approved Premises ("AP") (it appears that it is possible for medium risk women to be admitted to an AP but that possibility is not well understood and the reality is that it is not available; that kind of accommodation being very over-subscribed in any event). This means there is little or no effective system of rehabilitative provision for that cohort. This is a cohort in which the state has invested a great deal of time and money (in imprisoning and rehabilitative work) only, the evidence suggests, for that investment to be at risk of being squandered on release. It also means that provision can become dependant on small charities and related

	acts of individual generosity, which is patchwork and may bring problems of unclear access and unclear criteria (as happened here). The evidence was that this was being looked at by the Probation Service, which does not generally provide specialist rehabilitation accommodation itself but which has an obvious interest in it being available and so is monitoring the situation. However the evidence was also that the situation is getting worse not better, particularly for women (who tend to have higher levels of self-harm), and this is despite things like the Corston review in 2007 and the case of Coll v SSJ ten years later, which found discrimination because of the gender disparity with respect to the availability of APs. There is now a similar lack, and apparent gender impact, with regard to specialist rehabilitation accommodation too. The circumstances creating the risk of other deaths therefore subsist, and might benefit from some renewed focus. Concern (2) is linked to the first, in that the probation officers, who have primary responsibility for finding accommodation and building release plans, need to understand what accommodation is and is not available. This case showed that no-one, including the relevant officer, realised that an AP might in theory have been available. It also showed a failure to appreciate that once the first specialist placement fell through, a second was very unlikely to be found and so CAS3 accommodation was realistically the only option. That therefore needed finding quickly, so that a support plan could be built around it. There does therefore seem to be a training need. TO S2R: S2R started providing this kind of specialist accommodation because there was such a pressing need for more of it. They are to be welcomed for having done so. However, like many small organisations which have grown, it appears that their systems have not always grown with them. Work is already being done, but there remains a continuing risk. Placement offers and the conditions and expectations which attach to them are too unclear. The recording of decisions around offers, withdrawal, and reconsideration, also needs to be better, not just to ensure that decisions are recorded, but also to ensure that decision-making is properly structured and takes all relevant matters into account. Withdrawing accommodation offers without first speaking to the requesting organisation (in this case staff at the prison) also gives rise to risks. As this case shows, these are critically important decisions, and great care is required.
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 05, 2025. 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 **Change Grow Live (West Sussex)** [redacted] **Forward Trust** 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: 11/11/2024  Nick ARMSTRONG KC Assistant Coroner for West Sussex, Brighton and Hove