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 Secretary of State for Defence**
1	**CORONER** I am Robert SIMPSON, Assistant Coroner for the coroner area of Berkshire
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 15 September 2023 I commenced an investigation into the death of Charlie Anthony OWEN aged 25. The investigation concluded at the end of the inquest on 29 November 2024. The conclusion of the inquest was that: The deceased ended his life by suicide. The assessment of the level of risk posed was appropriate as was the overall plan to address this risk. However there was a failure to pass on all of the pertinent risk management information to those making decisions; the full purpose of asking the deceased to return to barracks was not communicated effectively to him, protective factors mitigating the resulting lack of proximity to family, including meeting him or assessing his welfare on arrival, were not considered. These factors taken together may possibly have contributed to his death on that day.
4	**CIRCUMSTANCES OF THE DEATH** On the 11th September 2023 Charlie Anthony Owen was found deceased in his room at the Combermere Barracks, Windsor. On the 5th September 2023 he had taken action to end his own life which he aborted and sought help from his lieutenant. This was the second time that he had made, and aborted, an attempt to end his own life; both of which occurred in the context of relationship breakdown. The army arranged a medical and mental health assessment and Charlie denied current intent to end his life in all subsequent conversations with medical and army personnel. Charlie was still assessed as posing a risk to himself and was called back to his battalion. This was for further assessment and treatment as well as a return to work. Not all relevant information was shared and considered when plans were made for his return. He left his family home in Wales on the 10th September; having prepared notes indicating an intent to end his life at some point prior to this. After returning to barracks he hung himself.

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) <u>Vulnerability Risk Management (VRM) process</u> I heard evidence that the army VRM guidance does not invite those attending case conferences to consider 'checking in' or meeting those assessed as posing a risk of self-harm on return to their unit. In this inquest no consideration was given to this possibility even though Charlie posed an elevated level of risk and had been initially placed under the VRM process whilst at home. This gives rise to a concern that the army does not know where soldiers who pose a risk are and does not facilitate additional support that may be necessary. I accept the evidence I heard that different units will have different requirements but this would not prevent them from giving consideration of this issue. <u>Training</u> I heard that suicide prevention training is not mandatory for army welfare officers/welfare NCOs. This gives rise to a concern that those specifically tasked to deal with people who are most likely to pose a risk of suicide or self harm are not best equipped to identify this and assist the individual. I heard evidence regarding the VRM process training. I am concerned that there is insufficient focus in that training on the actual aim including reducing risk and preventing suicide. A better understanding of risks and the purpose of VRM seems likely to assist those tasked with running it. <u>Information sharing</u> Witnesses for the army have noted that information sharing between medical and command personnel poses challenges. I am concerned that the VRM process does not require adequate documentation of the information shared. The lack of detail contained within the case conference notes hindered this inquest's ability to establish precisely what risk information was shared. This gives rise to a concern that audits of effectiveness and potential learning points are being missed. I was concerned to hear that when a risk management and safety plan has been prepared by the Defence mental health services the information contained about relevant protective factors and safety actions is not necessarily shared with the Chain of Command. There is no prompt on the relevant template to remind of team of the potential benefit of sharing this information or requesting consent from the individual in question to do so which gives rise to a concern that this important information is not shared.
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 24, 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 **The family of Charlie Owen** I have also sent it to **MOD Defence Inquests Unit (DIU)** 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: 29/11/2024**  **Robert SIMPSON** **Assistant Coroner for** **Berkshire**