IN THE SURREY CORONER'S COURT
IN THE MATTER OF:

The Inquest Touching the Death of Luke Harry Brockwell Barnes
A Regulation 28 Report – Action to Prevent Future Deaths

1	**THIS REPORT IS BEING SENT TO:** [redacted] Chief Probation Officer HMPPS
2	**CORONER** Ms Susan Ridge, H.M. Assistant Coroner for Surrey
3	**CORONER'S LEGAL POWERS** I make this report under paragraph 7(1) of Schedule 5 to The Coroners and Justice Act 2009.
4	**INQUEST** An inquest into Mr Barnes death was opened on 14 May 2024. The inquest was resumed and concluded on 16 December 2024 with further submissions in respect of Regulation 28 matters received on 29 January 2025 and 5 March 2025. The medical cause of Mr Barnes' death was: 1a. [redacted] toxicity With respect to where, when and how Mr Barnes came by his death it was recorded at Box 3 of the Record of Inquest as follows: Luke Harry Brockwell BARNES was found dead at his home in Cobham on 9 February 2024. He had taken sufficient [redacted] to result in his death from [redacted] toxicity. His death was formally recorded by paramedics at 1134 hours that same day.

	The inquest concluded with a short form conclusion of 'Drug related'.
5	**CIRCUMSTANCES OF THE DEATH** During the course of the inquest the court heard that Mr Barnes had a diagnosis of autism and a personality disorder with a history of previous convictions. He had long-term drug abuse issues including purchasing drugs online. At the time of his death Mr Barnes was subject to probation service supervision following a short period on licence and a 12 month community order made by Guildford Crown Court, this included a Drug Rehabilitation Requirement (DRR). The DRR was not implemented by the probation service. Mr Barnes was referred to a similar programme, which he attended, but which could not require him to undergo regular drug testing. The coroner heard that any such alteration to sentence requires the court itself to review the original sentence. That did not happen in Mr Barnes' case. Following his arrest in April 2023 Mr Barnes had been referred by Westminster Court Probation Service to the Liaison and Diversion Service at Westminster Magistrates Court for assessment and review. A report was prepared by a specialist practitioner for intellectual disabilities and learning disabilities. That report included insights into his character and behaviour, discussion about his autism and recommendations as to how best to manage Mr Barnes in the future. In June 2023 post sentence probation supervision for Mr Barnes was passed from London to Staines. The court heard that the report prepared by the Liaison and Diversion Service specialist practitioner was not seen by or was not available to probation staff in Staines.

6	**CORONER'S CONCERNS** The **MATTERS OF CONCERN** are: a.Probation staff are not always aware of or have access to relevant and/or specialist medical reports prepared for Liaison and Diversion Service and other bodies including mental health providers. Further evidence obtained from HMPPS indicates that reports prepared for Liaison and Diversion Service or mental health service providers by specialist medical practitioners (including learning disability practitioners) may not always be notified to the probation service and that the sharing of such information relies to an extent on ad hoc arrangements. The coroner has been told that this issue has been identified previously in a Serious Further Offences Review. b.Whether there is sufficient training for all frontline probation service staff about neurodiverse conditions and their impact on post sentence supervision. The Court heard from Mr Barnes' probation practitioner, they had limited awareness of neurodiversity issues as they might affect the supervision of Mr Barnes or probation service policy in this area. Although further evidence from HMPPS confirms that since 2021 all trainee probation officers are required to attend a face-to-face training session on neurodiversity and probation officers and qualified probation officers have training available to them it is not clear if this training is sufficient and for all frontline probation staff. c. That a loophole exists whereby a sentence of the court, not actioned by probation service staff, (in this case a DRR) might not be referred back to the court for review.
7	**ACTION SHOULD BE TAKEN** In my opinion action should be taken to prevent future deaths and I believe that the people listed in paragraph one above have the power to take such action.

8	**YOUR RESPONSE** You are under a duty to respond to this report within 56 days of its date; I may extend that period on request. Your response must contain details of action taken or proposed to be taken, setting out the timetable for such action. Otherwise you must explain why no action is proposed.
9	**COPIES** I have sent a copy of this report to the following: 1. Chief Coroner 2. Mr Barnes family
10	**Signed:** **Susan Ridge** **H.M Assistant Coroner for Surrey** **Dated 11 March 2025**