Appendix 16.1 – Templates for PDF reports

REGULATION 28: REPORT TO PREVENT FUTURE DEATHS

	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO:** **1. THE GOVERNOR HMP ROCHESTER**
1	**CORONER** I am Patricia Harding, senior coroner, for the coroner area of Mid Kent and Medway
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 16th February 2024 I commenced an investigation into the death of Sean Higgins 45 years. The investigation concluded at the end of the inquest on 17th February 2025. The conclusion of the inquest was suicide, the medical cause of death1a Suspension
4	**CIRCUMSTANCES OF THE DEATH** Sean Higgins had a long history of mental health issues and substance abuse. His exact diagnosis was a matter of differing opinion between clinicians but alternative diagnoses included paranoid schizophrenia, drug induced psychosis and personality disorder for which he was prescribed antipsychotic and anti-anxiety medication. In 2019 he was sentenced to 12 years imprisonment and in 2021 he was transferred to HMP Rochester. Between September 2022 and August 2023 he had been placed on ACCT procedures on five previous occasions whilst at HMP Rochester after concerns of self-harm were raised including after making ligatures. The inquest investigated the last few months of his life when he finished psychological therapy and was removed from the mental health team's caseload. Coincident with this but not apparently because of it he started to self isolate and was managed under CSIP procedures. In December 2023 he stopped taking his medication. His mental health deteriorated. In early January 2024 an ACCT was opened when the deceased was discovered with a ligature [redacted]. The ACCT remained open for the whole of January, with six reviews being held. The mental health team did not attend any of the reviews, although they provided a verbal contribution for one which did not contain relevant information from which an accurate risk assessment could be made. The ACCT was closed without the support actions being completed (which included the prisoner engaging with the mental health team) and without consideration of the available

	documentation. The Custodial Manager and supervising officer on the wing who were responsible for closing the ACCT had been sent emails echoing that which was in the ongoing record that the deceased was hallucinating and was talking of hanging himself which they had not read. There were multiple failures follow policies for both the prison and mental health staff. The deceased fashioned a ligature [redacted] six days later and left a note stating his mental health was torture. He had not received medication for 45 days and had not seen anyone from the mental health team for over two months.
	CORONER'S CONCERNS During the course of the inquest the evidence 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. – (1) Although HMP Rochester had addressed many of the concerns raised by the PPO in advance of the inquest, evidence was given at the inquest that some officers chairing reviews did not read relevant documentation beyond the last ACCT review prior to the review taking place. Although they additionally looked at the last CSIP review where the processes were running in tandem, they did not read the ongoing record or Nomis case notes and were unable to conduct an accurate assessment of risk as a result (2) Some of the officers chairing reviews did not understand how to complete the support plan paperwork such that the ACCT was closed when some of the support plans had not started or had not been completed
6	**ACTION SHOULD BE TAKEN** In my opinion action should be taken to prevent future deaths and I believe you Governor HMP Rochester 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 7th May 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: family's legal representatives, Oxleas NHS Foundation Trust. I have also sent it to Prison & Probation Ombudsman 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 other 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.
9	**11th March 2025 Patricia Harding HM Senior Coroner Mid Kent & Medway**