

## REGULATION 28: REPORT TO PREVENT FUTURE DEATHS

*NOTE: This form is to be used **after** an inquest.*

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|   | <b>REGULATION 28 REPORT TO PREVENT FUTURE DEATHS</b><br><br><b>THIS REPORT IS BEING SENT TO:</b><br><br><b>1. NHS England</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |
| 1 | <b>CORONER</b><br><br>I am Miss Sarah Middleton, Assistant Coroner, for the Coroner Area of City of Kingston Upon Hull and the County of the East Riding of Yorkshire.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       |
| 2 | <b>CORONER'S LEGAL POWERS</b><br><br>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 | <b>INVESTIGATION and INQUEST</b><br><br>On 31 <sup>st</sup> October 2023 I commenced an investigation into the death of Declan Carr aged 26 years. The investigation concluded at the end of the inquest on 3rd October 2025. The inquest was heard by a Jury.<br>The narrative conclusion of the inquest was:<br><br>On 28th August 2023 Declan Lewis Carr died [REDACTED] hang himself in his cell at HMP Humber, his intention was unknown due to him having consumed synthetic cannabinoids prior to his death.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          |
| 4 | <b>CIRCUMSTANCES OF THE DEATH as determined by the Jury</b><br><br>On 28th August 2023 at approximately 0543 hours Declan Carr was found in his cell on the Mike Wing at HMP Humber in Everthorpe.<br>He was declared deceased at 0620 hours by paramedics.<br>Declan [REDACTED] but we are unable to determine his intention, due to the presence of synthetic cannabinoids in his system, which could have had an effect on his state of mind.<br>Whilst at HMP Hull, Declan was referred by the DART team to mental health services on 22nd June 2023, but no further action was taken following a remote triage. The lack of communication to Declan regarding this decision was a failure.<br>Following Declan's move from HMP Hull to HMP Humber on 16th August 2023, there was no handover from psychosocial support for substance misuse issues, which is a failure in communication.<br>On arrival at HMP Humber on 16th August 2023 Declan underwent a Healthcare reception screening which we have found was insufficient.<br>There was a serious failure to complete the EDiC form by multiple prison personnel during the induction and therefore the standard of induction was insufficient at HMP Humber.<br>During his time at HMP Humber, Declan was not allocated a Keyworker, this is a failure.<br>All failures identified were not causative of Mr Declan Carr's death. |

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| 5 | <p><b><u>CORONER'S CONCERNS</u></b></p> <p>During the course of the inquest the evidence revealed matters giving rise to concern. In my opinion there is a risk that future deaths will occur unless action is taken. In the circumstances it is my statutory duty to report to you.</p> <p>The <b>MATTERS OF CONCERN</b> are as follows.</p> <p>Mr Carr was receiving psycho-social support regarding his substance misuse from healthcare services whilst he was in HMP Hull. He was due to have a further appointment with them on 16<sup>th</sup> August 2023. However, on this date Mr Carr was transferred to HMP Humber.</p> <p>HMP Humber were not made aware that Mr Carr was receiving psycho -social support and there was no handover to the support services in HMP Humber. There was then no support in place for Mr Carr.</p> <p>During the inquest I heard evidence that if Mr Carr had been receiving clinical support for drug misuse there would have been a handover for that to continue.</p> <p>I was also made aware that HMP Humber and HMP Hull now have a local policy in place to allow the prisons to share information about those that are receiving psycho-social support when transferring prisoners between these 2 prisons as they are the same agency that provide that service.</p> <p>However, I was informed that this a purely local arrangement and this is not a process that happens nationally and would cease if one of the prisons changed providers.</p> <p>If there is a lack of continuity of care for prisoners receiving psycho-social for drug misuse support then there is a risk of future deaths occurring.</p> |
| 6 | <p><b>ACTION SHOULD BE TAKEN</b></p> <p>In my opinion action should be taken to prevent future deaths and I believe you and your organisation has the power to take such action by ensuring thorough safeguarding reviews take place and all parties are notified of the conclusion and involved fully in the process.</p>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            |
| 7 | <p><b>YOUR RESPONSE</b></p> <p>You are under a duty to respond to this report within 56 days of the date of this report, namely by 15<sup>th</sup> December 2025. I, the coroner, may extend the period.</p> <p>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.</p>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          |
| 8 | <p><b>COPIES and PUBLICATION</b></p> <p>I have sent a copy of my report to the Chief Coroner and to the following Interested Persons; the family of Declan Carr, HMP Humber and HMP Hull and Spectrum Healthcare.</p> <p>I am also under a duty to send the Chief Coroner a copy of your response and all interested persons who in my opinion should receive it.</p> <p>I may also send a copy of your response to any person who I believe may find it useful</p>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   |

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|   | <p>or of interest.</p> <p>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.</p> <p>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.</p> |
| 9 | <b>Dated: 20<sup>th</sup> October 2025</b>                                                                                                                                                                                                                                                                                                                                                 |