

REGULATION 28: REPORT TO PREVENT FUTURE DEATHS

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

	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS THIS REPORT IS BEING SENT TO: 1. HCRG CARE GROUP, The Heath Business & Technical Park, Runcorn, Cheshire, WA7 4QX
1	CORONER I am STEPHEN SIMBLET KC assistant coroner, for the coroner area of Essex.
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 20 th March 2024, I commenced an investigation into the death of Steven Roy Davidson. The investigation concluded at the end of the inquest on 22 nd October 2025. The conclusion of the inquest was a narrative conclusion, with the jury including the finding that where he created a ligature [REDACTED] while a convicted but unsentenced prisoner in Chelmsford Prison. They also found (albeit without it being causative) that important information about the deceased and previous acts of self- harm had not been passed on.
4	CIRCUMSTANCES OF THE DEATH The deceased died while in prison. He had been in prison on a previous occasion, in 2012- 13, during which he had self- harmed on a number of occasions, including ligaturing himself to the point of unconsciousness on more than one occasion, [REDACTED]. He had during that prison stay also been [REDACTED] in his cell. This information was contained and documented within the System One Healthcare Records, which were available to the staff in Chelmsford Prison. However, the evidence from all of the healthcare witnesses involved, which included a number of Registered Mental Nurses carrying out a mental health review of the deceased's care, and the Nurse conducting the initial Reception Health Screen, was that none of those people were aware of the deceased's history. Evidence was given that such past history is clinically significant to any assessment of the risk of self harm. The evidence from some of these staff was that they had not been able to navigate the records very easily, and/or despite interrogating the records, had not found this important information. There was evidence given from senior personnel in the company involved in supplying health care to Chelmsford and other prisons that it is possible to word- search for words such as, "self harm" or "suicide".
5	<u>CORONER'S CONCERNS</u>

	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) Health Care Staff at HMP Chelmsford say that they are: (i) not able to navigate the System One records sufficiently well to find information about previous incidents of self- harm in prison; and/ or (ii) not sufficiently aware of the importance of searching the records made by clinicians during previous prison stays when conducting Reception Health Screens and/ or reviews of a prisoner's mental health needs. (iii) May not be sufficiently trained to understand and utilise System One records to find previous history, including incidents of self- harm in custody.			
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 15th December 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 : (1) [REDACTED], the father of the deceased; (2) The Ministry of Justice; I am also under a duty to send the Chief Coroner a copy of your response. 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	<table border="0" style="width: 100%;"> <tr> <td style="width: 40%;">[DATE] 21st October 2025</td> <td style="width: 30%; text-align: center;">[SIGNED BY CORONER]</td> <td style="width: 30%; text-align: center;">[REDACTED]</td> </tr> </table>	[DATE] 21 st October 2025	[SIGNED BY CORONER]	[REDACTED]
[DATE] 21 st October 2025	[SIGNED BY CORONER]	[REDACTED]		