ANNEX A

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. Minister of State for Prisons, Parole and Probation**
1	**CORONER** 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	**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 26th October 2023 I commenced an investigation into the death of Scott Stepjhen Berry aged 37 years. The investigation concluded at the end of the inquest on 13th October 2025. The Inquest was heard with a Jury. The narrative conclusion of the inquest was: Mr. Berry deliberately chose to suspend himself [redacted], but the evidence does not fully explain whether or not he intended that the outcome be fatal.
4	**CIRCUMSTANCES OF THE DEATH as determined by the Jury** At the time of his death, Mr. Berry had been in prison for 15 years serving an IPP with several unsuccessful parole applications. Mr. Berry had a long-standing history of mental health problems and diagnosis of emotionally unstable personality disorder, attention deficit hyperactivity disorder, post-traumatic stress disorder and anxiety. The effects of these were heavily exacerbated by Mr. Berry's' sense of injustice regarding his IPP sentence, which he spoke about frequently to prison, healthcare and other staff. On 12th October 2023, it was Mr. Berry's late Father's birthday and Mr. Berry was displaying low mood and made statements about wanting to take his own life. An ACCT was appropriately opened to monitor Mr. Berry at a high frequency. Mr. Berry was checked at 18:32 and again at 18:52 at which time he was found hanging [redacted] Mr. Berry was attended to by prison and healthcare staff and was successfully resuscitated after CPR. Paramedics attended and Mr. Berry was taken to Hull Royal Infirmary where he was treated by hospital staff, but due to sustaining a hypoxic brain, he died on 21st October 2023. Although, Mr. Berry was found to have [redacted] in his system from the blood samples taken on hospital admission, there is not enough evidence to suggest that Mr. Berry was under the influence of [redacted] on 12th October 2023.

5	**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 will occur unless action is taken. In the circumstances it is my statutory duty to report to you. The **MATTERS OF CONCERN** are as follows: Mr Berry was one of many Imprisonment for Public Protection (IPP) prisoners at HMP Humber. Mr Berry was frustrated by his sentence and had little hope of being released which he voiced to a number of staff and professionals. Mr Berry had been sentenced to a tariff of 2 years and 4 months and was till in prison 15 years later. These sentences were abolished in 2012. I have had regard to the HMPPS Action Plan for those on Imprisonment for Public Protection sentences and the strategy to address the challenges faced by IPP prisoners. In evidence I heard that the Action Plan is assisting those on such sentences in the community. The numbers of prisoners on licence has fallen. However, there still remains a large number of unreleased IPP prisoners in prison. For those who remain detained in prison, some many years after their original tariff, there is still a long period for them to wait for a review. These prisoners are, in many cases, still waiting for parole board review and not all have access to Offender Delivery Programmes or therapeutic and progression units to assist them. These prisoners are suffering with their mental health and still have little hope of release. If action is not taken with regard to those still serving these sentences in prison, then there is a risk of future deaths occurring. The making of a Regulation 28 report in this regard was supported by the Safer Custody team at HMP Humber so that a considered response can be provided in relation to this matter and the concerns raised.
6	**ACTION SHOULD BE TAKEN** 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.
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; the family of Scott Berry, HMP Humber and Spectrum Healthcare. I have also sent it to: The Prison and Probation Ombudsman HM Inspector of Prisons

	Executive Director of Inquest 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. 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: 20th October 2025**