REGULATION 28: REPORT TO PREVENT FUTURE DEATHS

	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO:** **1. Chief Executive Officer of Essex Partnership University NHS Foundation Trust** **2. The Ministry of Justice** **3. HM Prison and Probation Service** **4. HCRG**
1	**CORONER** I am Sean Horstead, Area 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 6th February 2024 I commenced an investigation into the death of STUART CHRISTOPHER JAMES BERRY, aged 40 years, who died at Broomfield Hospital, Chelmsford, Essex on 1st February 2024. The investigation concluded at the end of an article 2 jury inquest on the 5th December 2025. On the 27th January 2024 Mr Berry was remanded to HMP Chelmsford by the Chelmsford Magistrates Court in respect of an alleged offence on the 23rd January. He had previously been employed as a Special Constable with the Metropolitan Police Service and as a Prison Officer and this was his first experience of remand to prison custody. At around 21.00 hours on the 27th January, some 7 hours after his arrival at the Prison, Mr Berry was discovered by officers suspended [redacted] He was cut down, CPR initiated, and the emergency services called. Despite optimal emergency and subsequent medical treatment, he died at Broomfield Hospital on 1st February 2024. The medical cause of death was confirmed as '1a Hanging'. The jury returned a *short form conclusion* of *'Suicide'* with an '*expanded Narrative Conclusion'* recording that the deceased had taken his own life in the

	context of multiple failures in the care, management and treatment provided to him by the Essex Partnership NHS Foundation Trust (EPUT) over a six-month period preceding the death, which probably more than minimally contributed to the death. In respect to Mr Berry's short period at HMP Chelmsford on the 27th January, the jury concluded that the assessment and management of Mr Berry's risk of suicide *"demonstrated serious failings"* and that *"the whole process was severely impeded by poor completion of the ACCT and questionable input in respect of observations and conversations."* Two specific *gross failures to provide basic care*, amounting to neglect, were identified by the jury as having contributed to the death: Firstly, a failure on the part of the HMP Chelmsford reception nurse employed by HCRG to share important risk information with prison reception staff. Secondly, the failure of prison staff, who had opened an ACCT immediately following Mr Berry's arrival at the prison, to ensure *on the basis of the information relating to his risk of suicide known to them at the time,* that he was made subject to Constant Supervision, instead setting observations at two per hour prior, prior to placing him in a cell with obvious, accessible ligature points in the form of the bars at the cell window.
4	**CIRCUMSTANCES OF THE DEATH:** Mr Berry's history of mental health issues (variously diagnosed as Bi-Polar Disorder, Cyclothymia and Depression and anxiety) extended back to 2015; he had been under the care of the EPUT Community Mental Health Team (CMHT) until early 2023 when he was discharged following lack of engagement. Over those years he had been prescribed a combination of anti-depressant and anti-psychotic medication by EPUT clinicians and his GP. Having separated from his partner and young children in the summer of 2023, Mr Berry began to misuse significant quantities of cocaine on a daily basis contributing to a serious exacerbation of his mental health issues and an attempt to take his own life, by way of ligature in a public place, on 20th October 2023. From the end of August 2023 through to his death Mr Berry attended the Mental Health Urgent Care Department (MHUCD) based at Basildon Hospital in mental health crisis on five occasions. Following one such presentation at the end of August he was referred back to the CMHT and allocated a Care Coordinator. After a further sustained period of cocaine abuse and in acute mental health crisis, on the 25th January 2024 Mr Berry contacted the East of England Ambulance Service expressing his intention to end his life. He was subsequently located by the Police, assessed by the crew of the *Mental Health Joint Response Car* and, given his high risk of suicide and self-harm, he was

transported to the (EPUT) MHUCD where he was triaged and waited overnight to be assessed by the mental health team.

On the morning of the 26th January Mr Berry was traced to the MHUCD by police investigating an alleged incident on the 23rd January. Prior to Mr Berry being seen by a clinician and assessed at the UCD, Essex Police Officers, on the back of the earlier 'status enquiry', attended and, having been told that Mr Berry had not been detained by the mental health clinicians, he was arrested and taken to Grays Police Station. There he was assessed by both Health Care Professionals and a Registered Mental Health Nurse. Given his high risk of suicide and self-harm, throughout his detention at the Police Station Mr Berry was subject to Constant Observations by officers at his open cell door. He was subsequently charged and remanded to the Magistrates' Court.

Mr Berry was further reviewed at Chelmsford Magistrates' Court on the morning of the 27th January by the same RMN as had assessed him at the Police station. He remained under constant supervision and then remanded by the Court to HMP Chelmsford. He was transported to the Prison, still under constant supervision, arriving at around 14.00 hours.

In advance of his arrival, the reception nurse at HMP Chelmsford was informed by the EPUT psychiatric nurse based at the Court, initially by telephone and then in an email, in terms, that Mr Berry was deemed an *'Extreme Risk of Suicide'* (written in upper case, italicised and in bold red ink) attaching the Prisoner Warning Notice (PWN) which included the Report and the Supplementary Report arising from the RMN's assessments undertaken, respectively, at the police station the day before and the Magistrates' Court that morning. The prison reception nurse, employed by CRG, failed to share this information with prison staff; the jury found this to be a gross failure constituting neglect. Additionally, notwithstanding the information known to her, she did not seek to expedite a mental health review that day.

Although Reception Prison staff were unaware of the PWN or the email from the Court they had, separately, received details of Mr Berry's high suicide risk in the form of the Digital Person Escort Record and the SASH (suicide and self-harm document) provided to them at handover by the SERCO officers at his arrival at the Prison. An ACCT was opened as Mr Berry he previously been employed as a Special Constable with the Metropolitan Police Service and he was offered (and agreed to) Vulnerable Prisoner status and to be located in a single occupancy cell on the 'threes landing' on A-Wing, away from the main prisoner population.

In his Immediate Action Plan, rather than utilising *'Constant Supervision'*, the Supervising Officer decided that Mr Berry would be subject to two observations per hour. This decision was described by the jury to be a *"serious failure"* and the decision to place him in a cell with accessible metal bars in the window without constant supervision as "*an extreme failure"* that constituted neglect.

5	**The MATTERS OF CONCERN are as follows:** **<u>Re: EPUT</u>** A significant number of the causative failings identified in this case have previously informed PFDRs issued to EPUT and have claimed to have been addressed in responses to those PFDRs. In June 2024 a '*Thematic Analysis'* Review Document prepared by EPUT's 'Lessons Team' identified 'Triangulated Themes' from a review of (then) nine PFDRs issued in the Essex Coronial jurisdiction between June 2021 and January 2024. The Review acknowledged six 'Triangulated Themes' in respect of which failures causative of deaths had been, and continued to be, identified, including: *Communication; Training & Supervision; Record Keeping; Discharge Planning; Care Planning; Risk Assessment*. Multiple further PFDRs issued to EPUT in 2024 and through 2025 have raised very similar and related concerns. Of particular concern is the fact that in a response to a previous PFDR issued in 2023, the CEO of EPUT wrote a letter of response to this Coroner dated 21st September 2023 seeking to provide reassurance in regard to a number of features of EPUT performance. However, these same features were identified by the jury in Mr Berry's case to have been more than minimally causative of his death in early 2024. Specifically, matters identified as having contributed to Mr Berry's death arose over the period of provision of care that post-dated the CEO's letter in response the PFDR issued ie September 2023 through to late January 2024. <u>CONCERN</u>: During Mr Berry's inquest, once again, many of the continuing failings under precisely the themes identified in the 2024 'Thematic Review' *and in PFDR responses <u>prior</u> to that review as well as in the period <u>since</u> that Review*, have been identified as having informed the causative features contributing to the death of a patient under EPUT's care. In my opinion, the actions taken by EPUT to date to address the acknowledged failings reflected under the themes and issues referred to above have been, and remain, inadequate and incomplete, specifically: (a) <u>Failures in the performance of the CMHT and the allocated Care Coordinator</u> as required under the Care Programme Approach (CPA) and as mandated by EPUT policy. These failures indicated significant human error not detected by an insufficiently robust system and not therefore corrected prior to the death:

(b) Failures in Care Planning: specifically, a failure to appropriately up-date and document matters relating to Mr Berry's Care Plan consistent with Trust policy.

(c) Failures in Risk Assessments: specifically, failures to appropriately up-date and document matters relating to Mr Berry's risk assessment consistent with Trust policy.

(d) Failures in Documentation: in a number of acknowledged respects the electronic records were inadequate - and inconsistent with EPUT policy.

(e) Failure of joint working internally: the CC did not attempt to escalate or consult with EPUT colleagues via the regular weekly MTD meeting or any other type of Professionals' Meeting.

(f) Failure of joint working externally: the CC did not liaise at all with the external specialist substance misuse team, even though the cocaine misuse was a central aspect of his presentation and mental health deterioration.

(g) Failures in Communication within and between teams as above but also, crucially, including a failure to appropriately liaise with the deceased's Family to gather collateral information and to provide a carer's assessment and/or support to Mr Berry's family.

Re: MOJ:

Evidence was given by a senior Prison Officer working for Prison Learning and Development at HMP Chelmsford responsible for providing Prison Officer Entry Level Training (POELT) to new officers at HMP Chelmsford, regarding the training that would have been received by the officers involved in the opening and maintenance of Mr Berry's ACCT document. She confirmed that ACCT training is provided at HMP Chelmsford under an umbrella heading of Suicide and Self Harm (SASH) training and are covered in induction training. The witness was particularly critical of ACCT training at national level expressing concerns as to whether the said training was 'fit for purpose'. Evidence indicated that the training was long overdue revision. She confirmed that she had sent some five emails with course improvement proposals to which she had not received a single response.

The POELT witness raised a specific concern that the five-minute period allowed for 'Risk Awareness' training, as set out in the Safety Support Skills Module 3 Suicide and Self-harm contained in the HMPPS Learning & Development Manual, was wholly inadequate and relayed that she felt obliged to unilaterally extended this critically important aspect of the training to at least one hour.

CONCERN: In the context of the finding of the jury of a gross failure to ensure that Mr Berry was, in all the circumstances as known to the prison staff, subject to Constant Supervision, I am concerned that inadequate national training contributed to an over-reliance by prison staff on the subjective perception of an 'improvement' in a prisoner's transient presentation and demeanour over obvious and grave documented risk factors when assessing risk and setting observation levels. The reassurance provided by Mr Berry, (according to the Supervising Officer), appears to have been dangerously misleading and uncritically accepted notwithstanding the clear, high risk of suicide Mr Berry presented. This, in turn, gives rise to my concern (in the light of the evidence provided by the POELT trainer) that the exceptionally short time allocated in national prison officer training to equip officers with the requisite skills to assess, identify and records triggers, risk factors and protective factors is wholly inadequate.

CONCERN: A further concern raised by the evidence relates to the lack of any attempt to cost structural cell improvements to mitigate, in at least some cells on each wing, the most obvious of ligature points in the Victorian Prison estates' cells, namely the readily accessible fixed bars at the windows. Whilst other less obvious ligature points are potentially available in cells, all the (multiple) self-inflicted ligature related deaths at HMP Chelmsford in recent years have exclusively involved the use of the window bars.

The HMPPS Prison Group Director for Hertfordshire, Essex and Suffolk prisons undertook, following his evidence that such costings had not even been sought to date, to now ensure that such an exercise is undertaken. However, the concern remains that this is a national issue in relation to all Victorian or equivalent prisons and that absent even a costing exercise, steps to mitigate this serious, obvious and continuing risk will not be addressed.

HCRG

In addition to failing to share crucial and obviously relevant information regarding Mr Berry's extreme risk of suicide provided by the CPN at Court with prison staff, the jury found that the reception nurse, in the context of the clear information known to her, failed to: (a) document his risk of self-harm and suicide in the Systm One records and (b) failed to refer Mr Berry, that day, for an urgent review by the Mental Health team.

CONCERN: Such comprehensive shortcomings in performance in respect of information sharing, conduct of assessments, basic documentation and escalation/referral on to relevant colleagues indicates (a) a failure in training of a very concerning kind, alongside (b) a failure in HCRG monitoring of standards, supervision and quality assurance processes to identify and address such extensive failures in performance.

	Whilst submissions have been provided on behalf of HCRG indicating some steps taken/to be taken to address these concerns I am aware that the leadership of Health Care at HMP Chelmsford is presently in transition and that a number of the steps indicated (including the appointment of an Early Days In Custody Nurse) have yet to be fully instigated and are therefore incomplete. Accordingly, during the inquest the evidence revealed matters giving rise to concern and, 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.
6	**ACTION SHOULD BE TAKEN** In my opinion action should be taken to prevent future deaths and I believe you and 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 **Monday 9th March 2026**. 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: *Lawyers for the Family of the Deceased* [redacted], *former partner of the Deceased and the mother of his children* *Essex Police* *Thurrock and Brentwood Mind* *Midlands Partnership NHS Foundation Trust* *HM Inspectorate of Prisons* *The Independent Advisory Panel on Deaths in Custody*

	The Prison & Probation Ombudsman [redacted] *Consultant Forensic Psychiatrist and instructed Expert witness* 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	[redacted] **HM Area Coroner for Essex Sean Horstead** **12.01.2026**