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 [redacted] Minister of State for Prisons, Probation and reducing Offending**
1	**CORONER** I am Darren STEWART OBE, HM Area Coroner for the coroner area of Suffolk
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 25 July 2024 I commenced an investigation into the death of **Paul Christoper THOMPSON** aged **53.** The investigation concluded at the end of the inquest on 04 December 2025. The conclusion of the inquest was: **Suicide** The medical cause of death was confirmed as: **1a Multiple Injuries**
4	**CIRCUMSTANCES OF THE DEATH** **On 15th July 2024 at around 17.39 hours at Elmswell Railway Station, Paul Christoper THOMPSON was observed [redacted] which then struck Mr. THOMPSON causing his death. Police and ambulance attended and confirmed Mr. THOMPSON's death. Mr. THOMPSON's previous medical history included suffering from the condition of functional neurological disorder which had profoundly impacted on his life leading to the ending of his employment and him subsequently developing anxiety, depression and alcohol dependency.** **Since 27th March 2024, Mr. THOMPSON had been remanded in custody at HMP Norwich. During his time in custody Mr. THOMPSON had expressed suicidal ideation and been under the care of prison mental health services, appearing on occasions anxious and depressed. Mr. THOMPSON's suicidal ideation included thoughts of taking his own life by stepping into the path of an oncoming train. He had been placed on Assessment, Care in Custody and Teamwork (ACCT) care planning process during his time in custody which had resulted in a stabilisation of his condition and reduction in suicidal ideation. His care and treatment by prison mental health services was ongoing at the time of his release.** **On the 11th July 2024 Mr. THOMPSON appeared before Suffolk Magistrates Court**

	and was sentenced to 12 weeks custody which equated to the time he had served in prison up until that point. His immediate release was therefore directed. Returning to HMP Norwich late in the day, Mr. THOMPSON was advised that he would be released that evening and moved to the prison reception centre where he was to be out-processed. Mr. THOMPSON expressed concern at the speed of this process and that he would not be able to access personal effects including his mobile telephone and bank cards which, given the time of day (after normal business hours), had been locked away in the prison safe. Mr. THOMPSON appeared distressed at this and expressed suicidal ideation to a prison officer. In response, prison staff sought to reassure Mr. THOMPSON and arrangements were made for out of hours access to his personal effects and his bank cards were returned to him. He was then released from custody at around 19.20 hours, 11th July 2024. Prison staff at this point observed that Mr. THOMPSON appeared to have settled and was content with arrangements made for the return of his remaining personal effects. He had also stated that his son was a protective factor against acting on his earlier expressed suicidal thoughts. **Mr. THOMPSON had not been seen by mental health staff as part of his out-processing from prison. Concern was expressed the following day, 12th July 2024 by prison mental health staff that Mr. THOMPSON had been released before the correct discharge procedures relating to his mental health care and treatment could be followed. A referral was then made on the 12th July 2024 to the Community Mental Health Team in Durham where Mr. THOMPSON had his registered address and efforts were made to contact him by telephone. These were unsuccessful.** **On the 12th July 2024 Mr. THOMPSON presented to the probation office in Durham. The Durham Probation Office was not aware of his release and no appointment had been scheduled. During an exchange with the Duty Probation Officer, Mr. THOMPSON appeared anxious and emotional and reported experiencing suicidal thoughts, although added that he had no plans to act on these. Probation staff contacted the local mental health CRISIS Team, but Mr. THOMPSON refused to engage with them. He was given the CRISIS Team contact details and an appointment made for him to attend the Probation Office on the 19th July 2024.** **On the 13th July 2024 Mr. THOMPSON travelled by train from Durham to Bury Saint Edmunds to retrieve his mobile telephone from the Bury Saint Edmunds Police Station. He returned to Durham that evening. On the 15th July 2024 Mr THOMPSON bought a rail ticket from Durham to Stowmarket at 10.32 hours. He was observed at Elmswell Railway Station near the ticket machine at 17.15 hours and CCTV at the station then shows his movements around the station until around 17.29 hours. At 17.39 hours he is observed moving from the station platform onto the railway tracks and lying in the path of an oncoming freight train.** **Police enquiries revealed no suspicious circumstances or third-party involvement in the death. Police found a note from Mr. THOMPSON at his residence in Durham addressed to Family and expressing his final thoughts and wishes.** **A Postmortem Examination determined Mr. THOMPSON's medical cause of death as being due to Multiple Injuries. No alcohol or drugs were found to be present in Mr. THOMPSON's body at the time of his death.**
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 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:

	The evidence received at Inquest indicated that inadequate arrangements existed at HMP Norwich to provide for the release of prisoners in receipt of mental health care during out of hours periods. In line with procedures in place at HMP Norwich, Mr. Thompson should have been seen by the mental health team treating him so that appropriate arrangements could be put in place for follow up care and treatment in the community. This did not occur. The mental health team treating Mr. Thompson were only made aware of the fact that he had been released when it was mentioned the following day during a general staff briefing. In addition, Mr. Thompson was not given clear information around when to report to Probation Services, nor were Probation Services advised in a timely manner of Mr. Thompson's release. As a consequence, when Mr. Thompson presented to Durham Probation Office the day after his release (12th July 2024), staff at the Probation Office in Durham had no knowledge of him or the fact of his release. Neither the failure to properly out-process Mr. Thompson from mental health services at HMP Norwich, nor the failure to inform Probation Services in Durham of Mr. Thompson's release made a material contribution to his death. However, I am concerned that the evidence heard at Mr. Thompson's Inquest reveals shortcomings in the internal passage of information at HMP Norwich concerning the release of prisoners in receipt of mental health care and treatment, particularly those who have expressed recent suicidal ideation. In addition, I am concerned as to the adequacy of information passage to the Probation Service relating to the release of prisoners from custody. In another case these failures may give rise to a risk of death.
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 April 3rd, 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 **Family of Paul Christoper THOMPSON** I have also sent it to **Prison and Probation Ombudsman** **Norfolk and Suffolk NHS Foundation Trust** **Governor, HMP Norwich**

	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	**Dated: 06/02/2026** [redacted] **Darren STEWART OBE** **HM Area Coroner for** **Suffolk**