

## Regulation 28: REPORT TO PREVENT FUTURE DEATHS

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

	<p><b>REGULATION 28 REPORT TO PREVENT DEATHS</b></p> <p><b>THIS REPORT IS BEING SENT TO:</b></p> <ol style="list-style-type: none"><li>1. Practice Plus Group</li><li>2. Midlands Partnership NHS Foundation Trust</li><li>3. [REDACTED]</li><li>4. Government Legal Department</li><li>5. [REDACTED]</li></ol>
<b>1</b>	<p><b>CORONER</b></p> <p>I am <b>James Puzey</b>, HM Assistant Coroner for the coroner area of Worcestershire.</p>
<b>2</b>	<p><b>CORONER'S LEGAL POWERS</b></p> <p>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.</p>
<b>3</b>	<p><b>INVESTIGATION AND INQUEST</b></p> <p>On <b>11 November 2024</b> I commenced an investigation and opened an inquest into the death of <b>Surendrakumar Patel</b>, aged 78.</p> <p>The investigation concluded at the end of the inquest on <b>10 March 2026</b>.</p> <p><b>The conclusion of the inquest was a Narrative Conclusion.</b></p> <p><b>QUESTIONNAIRE FINDINGS</b></p> <p><b>1. Mental Health Assessment</b></p> <p>(a) During SP's time at HMP Hewell, were sufficient steps taken to ensure a proper and timely assessment and potential diagnosis of his mental condition by a psychiatrist and for a treatment plan to be formulated?</p> <p><b>Answer: NO</b></p> <p>(c) If NO, did that failure possibly cause or contribute to SP's death on 31.10.24?</p> <p><b>Answer: CANNOT SAY</b></p> <hr/> <p><b>2. Weight Monitoring</b></p> <p>(a) Was SP's weight monitored with sufficient frequency and was sufficient action taken in response to weight loss?</p> <p><b>Answer: YES</b></p> <hr/> <p><b>3. Healthcare Plan</b></p> <p>(a) Were sufficient steps taken to ensure that a properly detailed healthcare plan was prepared after SP's food refusal and intention to end his life on 22 October 2024?</p> <p><b>Answer: YES</b></p>

	<p><b>4. Food Refusal Policy – Mental Capacity</b></p> <p>Food Refusal Policy required capacity assessment as soon as practicable.</p> <p><b>(a)</b> Should SP’s capacity to refuse food have been assessed urgently after 22 October 2024?</p> <p><b>Answer: YES</b></p> <p><b>(c)</b> Did that failure possibly contribute to death?</p> <p><b>Answer: CANNOT SAY</b></p> <hr/> <p><b>5. Self-Neglect</b></p> <p>If SP understood the consequences of not eating:</p> <p><b>(a)</b> Taking into account malnutrition, weight loss (9kg between 15–26 October 2024), stopping eating entirely (21–26 October 2024), and his statements about not wanting to live—was his death contributed to by self-neglect through malnutrition?</p> <p><b>Answer: YES</b></p> <p><b>Conclusion:</b></p> <p><b>Surendra Patel died from natural causes contributed to by self-neglect through malnutrition.</b></p>
4	<p><b>CIRCUMSTANCES OF THE DEATH</b></p> <p>Mr Patel died at the <b>Alexandra Hospital, Redditch</b>, on <b>31 October 2024</b>. He collapsed in hospital due to a lower respiratory tract infection, <b>contributed to by self-neglect through malnutrition</b>.</p> <p>He was on remand at HMP Hewell (15–27 Oct 2024) for murder. Prior to arrest, he had attempted to take his own life.</p> <p>While in prison:</p> <ul style="list-style-type: none"> <li>• He stopped eating between <b>21–26 October 2024</b></li> <li>• Expressed that he no longer wished to live</li> <li>• Weight declined from <b>46kg to 37kg</b></li> <li>• He was admitted with <b>acute kidney injury</b></li> </ul>
5	<p><b>CORONER’S CONCERNS (Matters of Concern)</b></p> <p><b>1. Healthcare staff (MPFT and PPG) lacked awareness of the food refusal policy:</b></p> <ol style="list-style-type: none"> <li>a. Failure to recognise that a mental capacity assessment was required as soon as food refusal began</li> <li>b. Failure to consider hospital transfer for prisoners severely weakened by weight loss</li> <li>c. Failure to expedite full medical assessment by a senior healthcare professional, including psychiatric assessment where physical health posed a risk to survival</li> <li>d. Failure to consider and advocate for family contact</li> </ol> <p><b>2. Prison staff lacked awareness of HMP Hewell food refusal policy, including:</b></p>

	<ul style="list-style-type: none"> <li>• Not informing Next of Kin of the prisoner's decision to refuse food/fluids</li> <li>• Not asking the prisoner whether such information should be shared</li> </ul>
<b>6</b>	<p><b>ACTION SHOULD BE TAKEN</b></p> <p>In my opinion, action should be taken to prevent future deaths, and you (and/or your organisation) have the power to take such action.</p>
<b>7</b>	<p><b>YOUR RESPONSE</b></p> <p>You are under a duty to respond within <b>56 days</b> of the date of this report - <b>by 5 May 2026</b>.</p> <p>Your response must include details of action taken or proposed, with a timetable, explanation of why no action is proposed.</p>
<b>8</b>	<p><b>COPIES AND PUBLICATION</b></p> <p>A copy has been sent to the Chief Coroner and to the following Interested Persons:</p> <ul style="list-style-type: none"> <li>• Practice Plus Group</li> <li>• Midlands Partnership NHS Foundation Trust</li> <li>• [REDACTED]</li> <li>• Government Legal Department</li> </ul> <p>Also copied to:</p> <ul style="list-style-type: none"> <li>• [REDACTED] (who may find it useful)</li> </ul> <p>Responses may be published by the Chief Coroner in full, redacted, or summary form.</p> <p>You may make representations regarding publication at the time of your response.</p>
<b>9</b>	<p><b>10 March 2026</b></p> <p><b>James Puzey</b></p> <p>HM Assistant Coroner for Worcestershire</p>