	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO:** [redacted] **Director of Probation** **70 Petty France** **LONDON** **SW1H 9EX**
1	**CORONER** I am Mr Andrew Haigh senior coroner for the coroner area of Staffordshire South
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 3 January 2014 I commenced an investigation into the death of Mark Groombridge aged 52 years. The investigation concluded at the end of the inquest on 16 April 2015. The conclusion of the inquest was suicide whilst suffering severe depression.
4	**CIRCUMSTANCES OF THE DEATH** Mr Groombridge had been in the community on licence from prison. On 12 December 2013 a warrant for his recall was issued. On 14 December he was arrested when he was an inpatient in a psychiatric unit and taken to HMP Dovegate. On 27 December he killed himself by jumping head first from a bed in the health care centre at the prison.
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. – (1) Before the recall paperwork was issued there was no direct conversation between the local offender manager and the clinician responsible for Mr Groombridge's care in hospital. Should it not be policy for such a discussion to take place in any case where an offender is in hospital (be it for physical or mental reasons) before the recall is issued? (2) There was confusion about the recall process. The local offender manager believed that recall papers could be sent to the central NOMS unit in London and that they could be held there pending further direction. The evidence from London

	was that this would never happen and all recall requests are processed according to their urgency. Should all probation staff be reminded of what the correct process is?
6	**ACTION SHOULD BE TAKEN** In my opinion action should be taken to prevent future deaths and I believe you 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 12 June 2015. 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: [redacted] – widow of the deceased Harrison Bundey – solicitors for the family DLA Piper – solicitors for HMP Dovegate Treasury Solicitor – solicitors for the probation service Capsticks – solicitors for the mental health trust Independent Monitoring Board for HMP Dovegate 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	**17 April 2015**  Andrew A Haigh HM Senior Coroner Staffordshire (South)