SPECIMEN: REPORT TO PREVENT FUTURE DEATHS (1)

	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO:** **1. Chief Constable, West Mercia Constabulary**
1	**CORONER** I am DAVID DONALD WILLIAM REID, HM Assistant Coroner, for the coroner area of Worcestershire.
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 2 June 2015 I commenced an investigation into the death of STEWART AKINS, then aged 51. The investigation concluded at the end of the inquest on 3 March 2016. The conclusion of the inquest was a narrative conclusion. The medical cause of death was 1a. Extensive head injury; 1b. Collision by train.
4	**CIRCUMSTANCES OF THE DEATH** The narrative conclusion stated: "On 23.5.15 Stewart Akins was arrested on suspicion of having committed two domestic assaults. He was taken to Worcester Police Station, where his detention was authorised. Throughout his time in custody it was recorded that Mr. Akins repeatedly stated his intention to end his own life, and he was properly viewed as presenting a high risk of suicide and/or self-harm. When he made his first appearance before the Worcester Magistrates' Court on 25.5.15, the Court was not told of this risk and no application was made for him to be remanded in custody because of that risk and for his own protection. Later that same day, having been released on conditional bail, he took his own life by placing himself in the path of a train on a railway line near Malvern Wells."
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) Throughout Mr. Akins' time in custody, entries were made on the custody record which recorded his repeatedly stated intention to end his own life. Statements to that effect were recorded as having been made, inter alia, to the Custody Sergeant, [redacted] to a nurse, to a Forensic Medical Examiner [redacted] and to the officer in charge of the investigation [redacted] at the end of his police interview. The view was taken that he presented a high risk of suicide/self-harm. (2) The officer in charge of the investigation into the offences with which Mr. Akins was eventually charged, [redacted] submitted an MG7 remand application form for consideration by the Crown Prosecution Service, and with a view to bail being opposed in the Magistrates' Court. In that form, she set out objections on

	a number of grounds including a remand for Mr. Akins' own protection. However, in giving details substantiating that particular ground for opposing bail she stated: *"AKINS has a problem with alcohol and mental health, clearly a combination that does not mix well. AKINS spoke of his suffering with post traumatic stress disorder (PTSD) and there is a real concern that, being charged with offences and now being NFA, he may pose a significant risk to not only those he encounters, but also to himself. It is therefore requested that a remand in custody be sought for AKINS own protection."* (3) [redacted] evidence at the inquest was that those details substantiating that ground for opposing bail (for Mr. Akins' own protection) were based solely on her own dealings with Mr. Akins, and not on what was recorded in the Custody Record. In fact, she was not aware of any of the entries recorded on the Custody Record and was therefore not aware of the level of risk of suicide/self-harm which those in charge of his detention felt that Mr. Akins presented. She had not sought to check the Custody Record for any such entries, nor to speak to the Custody Sergeant, nor had the Custody Sergeant sought to make her aware of such entries. (4) Because [redacted] was unaware of the contents of these entries in the Custody Record, the description in the MG7 of the risk of suicide/self-harm which Mr. Akins presented was significantly downplayed. (5) In addition to that under-reporting of risk, prior to the hearing in the Magistrates' Court, [redacted] was informed by the Senior Crown Prosecutor that she was considering agreeing to bail with certain conditions. Those conditions did not address the issue of risk of suicide/self-harm, but [redacted] accepted that she had not sought to raise this with the prosecutor. (6) A direct result of that under-reporting of risk of suicide/self-harm, and of [redacted] failure to raise it with the prosecutor, was that the prosecutor was minded to agree to conditional bail as proposed. No objections to bail were raised with the Magistrates, and conditional bail was duly granted. (7) I am therefore concerned that no chain of communication appeared to be in place whereby [redacted] was made aware of the risks highlighted in the Custody Record, so that an MG7 could be properly and fully prepared. (8) The explanations for this appear to be either: (i) that provision does not exist generally for such a chain of communication to be in place; or (ii) that provision does exist, and that [redacted] and/or the Custody Sergeant(s) failed to operate in accordance with such provision.
6	**ACTION SHOULD BE TAKEN** In my opinion action should be taken to prevent future deaths and I believe that 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 29 April 2016. 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] Chief Crown Prosecutor, CPS West Midlands. [redacted] (brother of deceased). 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	**3rd March 2016** **HM Assistant Coroner**