ANNEX A

REGULATION 28: REPORT TO PREVENT FUTURE DEATHS (1)

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

	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO:** **Essex Police** **EPUT** **Essex Community Rehabilitation Company**
1	**CORONER** I am Caroline Beasley-Murray, senior 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. [HYPERLINKS]
3	**INVESTIGATION and INQUEST** On 30 August 2016 I commenced an investigation into the death of Terence Joseph Pimm. The investigation concluded at the end of the inquest on 21 April 2017. The conclusion of the inquest was a narrative conclusion
4	**CIRCUMSTANCES OF THE DEATH** On 26 August 2016, Mr Pimm leapt from the 7th floor of the carpark at Southway Colchester. His death was confirmed there. At the time of his death he was wanted for failing to appear at court in the Metropolitan Police area. On 8 August he had been detained at Romford polic3e station under s136 MHA and taken to Goodmayes Hospital. On 25 August he met with his probation officer and mad3e threat6s to jump off a carpark. He was taken to A and E at Colchester Hospital, he was not ass3essed because he was under the influence of alcohol. He was collected by his mother and the next day he did not, as promised, hand himself into the police but went to the carpark.
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). Call handling and record-keeping at The Lakes 2). Call handling and record-keeping at the police custody suite 3). The sufficiency of guidance and training. **Cont....**

	4). To police call handlers as to whether an individual is, objectively, at an "immediate" risk. 5). To mental health assessors as to the circumstances in which the input of family Members should be sought. 6). The sufficiency of information sharing and coordination between the police, hospital Trust and probation service. 7). Training/guidance for mental health clinicians in relation to persons who are subject to a warrant. The evidence pointed to a lack of understanding as to the effect of a warrant upon the clinician's ability to assess and treat.
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 the 8th November 2017. 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 solicitors Leigh Day 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	**14 August 2017** **Caroline Beasley-Murray** **Senior Coroner Essex**