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:
	 National Probation Service – 102 Petty France, Westminster, London, SW1H 9AJ Ministry of Justice – 102 Petty France, Westminster, London, SW1H 9AJ
1	CORONER
	I am Kevin McLoughlin, Senior Coroner, for the coroner area of West Yorkshire (East)
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.
	INVESTIGATION and INQUEST
3	On 12 January 2017 an investigation was commenced into the death of Scott Patrick Carton, aged 38. The investigation concluded at the end of the inquest on 6 September 2018. The conclusion of the jury inquest was a narrative conclusion, including a medical cause of death of 1a Mixed Drug Poisoning.
	CIRCUMSTANCES OF THE DEATH
4	Scott Patrick Carton was released from Prison on Thursday, 5 January 2017 subject to licence conditions which included the requirement that he reside at approved premises known as the Westgate Project Hostel, Wakefield.
	After a turbulent weekend he was found dead in his room at the hostel on Tuesday, 10 January 2017. He died from the synergistic combination of drugs which had been prescribed for him - methadone, pregabalin and tramadol.

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. A probation report dated 18 July 2016 recommended Mr Carton's release on licence, notwithstanding a failed release on licence in summer 2015, in which he swiftly reverted to illicit drugs. The 18 July 2016 report envisaged specialist psychological input at Approved Premises which had access to psychological resources and a 'robust risk management plan in place'. In the event Mr Carton was sent to a different hostel which did not provide psychological inputs of the type envisaged, nor was any clear management plan communicated to the hostel staff who had to deal with Mr Carton's challenging behaviour. The likelihood of the hostel placement proving beneficial was thus compromised from the outset.
- 2. The parents' strenuous attempts to alert the Probation Service to the difficulties their son faced and the need for a placement at Approved Premises in a different area so as to avoid his drug connections, went unheeded.
- Evidence was taken from several witnesses who expressed views to the effect that the Westgate Project was not the appropriate place for Mr Carton as he needed 'medical help'
- 4. Having been diagnosed with an emotionally unstable personality disorder in 2013 Mr Carton needed to be allocated to a prison establishment which did provide appropriate psychological interventions. In the event he was placed in HMP Wealstun which did not provide such services. This diminished any prospect of him succeeding in the community when released.
- 5. Evidence taken at the inquest emphasised the paucity of psychological resource available to prisoners released on licence with emotionally unstable personality disorder and drug dependence issues. In consequence, individuals such as Mr Carton are released into the community when they are ill prepared. Unless adequate resources are available the result is likely to be that individuals will consume police and hospital resources as their condition deteriorates to the point where they are recalled to prison or their life ends in tragedy.
- To maximise the prospect of a successful reintegration into society, prisoners
 with mental health issues and/or drug dependence need appropriate support
 services to be in place prior to their release and arrangements made to have
 them registered with a GP immediately (so as to provide a conduit to community
 mental health services)

ACTION SHOULD BE TAKEN

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In my opinion action should be taken to prevent future deaths and I believe you in conjunction with the other organisations named have the power to take such action.

YOUR RESPONSE

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You are under a duty to respond to this report within 56 days of the date of this report, namely by 9 November, 2018, 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.

COPIES and PUBLICATION

I have sent a copy of my report to the Chief Coroner and to the following Interested Person:

(father of Scott Patrick Carton)

West Yorkshire Police

National Probation Service, Leeds

I have also sent it to the following who may find it useful or of interest:

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Parole Board 52 Queen Anne's Gate London WS1H 9AJ

Ref: Scott Patrick Carton (Prison number L68720)

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.

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Kevin McLoughlin Senior Coroner

West Yorkshire (East)

7 September 2018