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: 1. THE GOVERNOR HMP HUMBER (EVERTHORPE SITE) 2. 3. CORONER 1 I am ROSEMARY JANE BAXTER, Area Coroner for the Coroner area of KINGSTON UPON HULL AND THE EAST RIDING OF YORKSHIRE CORONER'S LEGAL POWERS 2 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** On 8 August 2014 I commenced an investigation into the death of CRAIG CHAPPELL, AGED 35 YEARS. The investigation concluded at the end of the inquest on 2 SEPTEMBER 2015. The conclusion of the inquest was SUICIDE together with the following NARRATIVE - Based on the evidence provided we the Jury conclude Craig Chappell had reached a crisis point. A number of factors within his personal life together with some system failures at HMP Humber (Everthorpe Site) contributed to him taking his own life. The medical cause of death was la Hanging II Alcohol and mixed drug intoxication CIRCUMSTANCES OF THE DEATH The deceased was found hanging in his cell at HMP Humber Everthorpe Site by staff at approximately 0630 hours on 8 August 2014. He had previously been subject to an ACCT document but this had been closed on 18 July 2014 having been open for some 24 hours or so only. Prior to his death he had been drinking Hooch which he had obtained in the prison and had taken prescription drugs. He suffered from depression issues which had been exacerbated by the recent death of his mother in December 2013, his own father's illness, he had suffered sexual abuse and had suffered constant pain in his leg following a below knee amputation. He had been receiving counselling in prison. **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) There was no formal mechanism for communicating family concerns to relevant decision making professionals and inadequate information sharing.
- (2) There was insufficient guidance given to prison staff on appropriate support for potential victims of abuse.
- (3) There was on occasions some inappropriate reliance by non health care staff on the subject's actual presentation and the subject's own views without investigating this further.

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 3 November 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

father of the deceased/ Slater & Gordon
daughter of the deceased

Humber NHS Foundation Trust/DACBeachcroft

Humberside Police Force – Abigail Combes, Force Solicitor

Clinical Reviewer

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 8 September 2015

[SIGNED BY AREA CORONER] Rosemay J. Baxle 9.