Regulation 28: REPORT TO PREVENT FUTURE DEATHS (1)

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

REGULATION 28 REPORT TO PREVENT DEATHS

THIS REPORT IS BEING SENT TO:

1 Michael Spurr, Head of Prison and Probation Service

1 CORONER

I am James Healy-Pratt, Assistant Coroner for the area of East Sussex.

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 16 February 2017 I commenced an investigation into the death of Dean Louis BARRELL, aged 34. The investigation concluded at the end of the inquest on 19 September 2018. The conclusion of the jury at the inquest was:

Hanging for the medical cause of death, and an Inquest conclusion of

Suicide, accompanied by various failings.

4 CIRCUMSTANCES OF THE DEATH (JURY FINDINGS)

Dean Barrell was remanded to HMP Highdown on 28 October 2016 and released on licence on 26 January 2017. Upon release he was homeless and living on the streets. His licence was subsequently revoked on 3 February 2017, he was arrested on 6 February 2017 and held in HMP Lewes, East Sussex, where he was undergoing alcohol detoxification. He was due to be released again on 17 February 2017 but this was not communicated to him and he believed he would be serving the remainder of his sentence, to be released on 29 April 2017.

Dean was found hanging in his cell on 13 February 2017. The jury reached a conclusion of suicide.

The jury found a number of failings, but the relevant failing in relation to this report is that "Dean's lack of awareness of his release on 17 February 2017 did have a direct and causal connection" to his death. Put another way, had Dean been properly and correctly informed that he was to be released in a matter of days, he may well have not taken his own life.

5 CORONER'S CONCERNS

The MATTERS OF CONCERN are as follows:

Dean Barrell clearly thought he was in HMP Lewes for the remainder of his sentence (some 3 months). This was incorrect, as he was due for release on 17 February 2017. Had Mr Barrell been informed sooner and in a timely fashion, he may well have not taken his own life.

It took the Prison and Probation Service 7 days to communicate the actual release date to HMP Lewes. HMP Lewes attempted then to communicate that within 3 hours of receipt, but Mr Barrell had by then taken his own life.

Fixed term recalls for breach of licence conditions are not complex. By their very nature, they can

result in short sentences to be served. Vulnerable prisoners deserve to know what their actual release date is, as soon as possible. A seven day delay as in this case, is simply unacceptable. The communication of the actual release date to a prisoner should, in this technological age, take less than 7 days.

6 ACTION SHOULD BE TAKEN

In my opinion action should be taken to prevent future deaths and I believe you (and/or 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 06 December 2018. 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 of Dean Barrell
HMP Lewes
The Forward Trust
Sussex Partnership NHS Foundation Trust

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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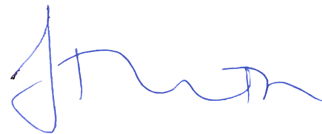

James HEALY-PRATT
Assistant Coroner for
East Sussex
Dated: 11 October 2018