REGULATION 28: REPORT TO PREVENT FUTURE DEATHS

	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO:** 1. Devon Partnership NHS Trust as lead for the South West Provider Collaborative (Devon Partnership NHS Trust, Cornwall Partnership NHS Foundation Trust, Livewell Southwest, Somerset Partnership NHS Foundation Trust, Elysium Healthcare, Cygnet Healthcare, Avon & Wiltshire Mental Health Partnership NHS Trust and Gloucestershire Health and Care NHS Foundation Trust) 2. Devon and Cornwall Police, Avon and Somerset Police, Wiltshire Police and Gloucestershire Police **3.** Prison and Probation Service
1	**CORONER** I am Nicholas Leslie Rheinberg, assistant coroner for the coroner area of Exeter and Greater Devon
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 27th April 2017 an investigation into the death of Lewis Charles Francis aged 20 was opened. The investigation concluded at the end of the inquest on 18th March 2020. The conclusion of the inquest was that Lewis died by suicide as a result of suspension by a ligature. Contributory factors included insufficient collaboration, communication and ownership between and within organisations along with a lack of understanding of the deceased's complex individual needs together with insufficient knowledge of the process and implementation of the Mental Health Act.
4	**CIRCUMSTANCES OF THE DEATH** Lewis Francis whilst acutely psychotic stabbed his Mother on 15th February 2017. He was arrested on suspicion of attempted murder and taken to Bridgwater Custody Suite. His psychosis continued at such a level that he was deemed unfit to be interviewed. Although his condition mandated a transfer to a medium secure mental health hospital for an assessment and / or treatment under section 2 and / or 3 of the Mental Health Act 1983 no ready facility existed for such a transfer and Lewis Francis was remanded in custody to HM Prison Exeter from where he was not transferred to a medium secure mental health hospital under the provisions of section 48 of the Mental Health Act 1983. He died at the prison as a result of self-inflicted suspension on 24th April 2017.
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) At present there is no mechanism for the ready transfer of a person in police custody within the police areas of Devon and Cornwall, Avon and Somerset, Wiltshire and Gloucestershire from police custody to a medium secure mental health facility for assessment / treatment under sections 2 and 3 of the Mental Health Act 1983 where

	such a person is suspected of or charged with a serious crime. Such an arrangement exists in the West Midlands where a Memorandum of Understanding has been developed and agreed between relevant agencies. (2) Evidence at the inquest suggested that there was an insufficient understanding of the special needs and vulnerabilities of those prisoners who are within the autistic spectrum
6	**ACTION SHOULD BE TAKEN** In my opinion action should be taken to prevent future deaths and I believe your organisations have the power to take such action as follows: (1) Evidence at the inquest suggested that steps were already being taken by the members of the South West Provider Collective to develop a Memorandum of Understanding between relevant organisations and agencies so as to provide for the transfer of mentally ill prisoners direct from police custody. Confirmation of the action be taken in this regard together with a time frame for implementation is required. (2) Further evidence at the inquest suggested that an initiative was already underway through the good offices of Avon and Somerset Police to cooperate with the South West Provider Collaborative in the development of the Memorandum of Understanding detailed above. Confirmation on behalf of the named police forces is required that they are willing to work towards the development of such a Memorandum of Understanding. (3) It appeared desirable that training with regard to the special needs and susceptibilities of those prisoners within the autistic spectrum be provided for prison officers, support staff and newly appointed prison officers undergoing training both in the form of face to face training and the provision of information through prison intranet systems.
7	**YOUR RESPONSE** You are under a duty to respond to this report within 56 days of the date of this report, namely by 20th May 2020. 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 namely the legal representatives of the interested persons participating in the inquest. 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	**Dated this 23rd day of March 2020** **SIGNED** **Assistant Coroner**