REGULATION 28: REPORT TO PREVENT FUTURE DEATHS (1)

	THIS REPORT IS BEING SENT TO: **David Ake & Co Solicitors, Falk House, Westgate, Leeds**
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.
3	**INVESTIGATION and INQUEST** On 17 April 2019 I commenced an investigation into the death of Richard Gordon Franks, aged 39. This concluded on 19 October 2021 when a jury returned a narrative conclusion recording a finding of suicide based upon the post mortem evidence that the cause of death was [redacted]
4	**CIRCUMSTANCES OF THE DEATH** Mr Franks was remanded in custody on 29 December 2018 and remained in HMP Leeds until his death on 12. April 2019. On 11 April 2019 he appeared at Leeds Crown Court. He was seen in conference that morning by his solicitor and counsel at which time he was said to be in a highly agitated state and to indicate he was likely to commit suicide if sentenced to two years imprisonment. On his return to prison at approximately 17:00 hours he reported erroneously that he had been sentenced to five years imprisonment when in fact his case had been adjourned for sentencing at a later date. Mr Franks was last seen alive at approximately 20:25 hours when locked in his single occupancy cell. At approximately 06:00 hours the following morning, 12 April 2019 he was found dead in his cell. A post mortem examination attributed his death to [redacted]
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) Mr Franks had a known history of self-harming and suicide attempts. His emotional state when seen at court on 11 April 2019 was triggered at least in part to his reaction to a development in the prosecution brought against him which he had not foreseen. His statement that he was likely to commit suicide was not communicated to either the security staff at the court or the prison staff. In consequence, the prison staff had no information concerning the events which took place at court. (2) Mr Franks somehow perceived that he had been sentenced to five years imprisonment, which was not the case. This false impression caused him to be in distress prior to being locked in his cell around 19:00 hours. (3) Had information concerning his emotions at court been relayed to the prison staff, this may have triggered a decision to open an ACCT – the process by which a prisoner is subject to increased monitoring and support. In the event no

	checks were made on him for some 10 hours. (4) At a previous hearing on 25.02.17 Mr Franks had made a comparable threat to kill himself as a result of what he perceived to be an adverse development in the case brought against him. At that time his signed consent authorising information to be passed to the prison was obtained and communicated to the prison. (5) The benefit of relaying helpful information to the prison intended to protect Mr Franks, does not seem to involve a breach of professional privilege. It would have been sufficient to request that the prison staff assess Mr Franks for themselves on his return in view of (unspecified) developments at court that day.
6	**ACTION SHOULD BE TAKEN** In my opinion action should be taken to prevent future deaths and I believe 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 Friday 17 December 2021. 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:- 1. [redacted], Mother of Mr Franks 2. HM Prison, Leeds, FAO: Governor [redacted] 3. Practice Plus Group (formerly Care UK Ltd), FAO: [redacted] 4. Dr [redacted], Locum GP, HMP Leeds I have also sent it to:- 1. [redacted], Park Square Barrister Chambers 2. The Law Society, The Law Society's Hall, 113 Chancery Lane, London 3. The General Council Of The Bar, 289-293 High Holborn, London who may find it useful or of interest. 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: Thursday 21st October 2021 Kevin McLoughlin KEVIN McLOUGHLIN Senior Coroner West Yorkshire (E)