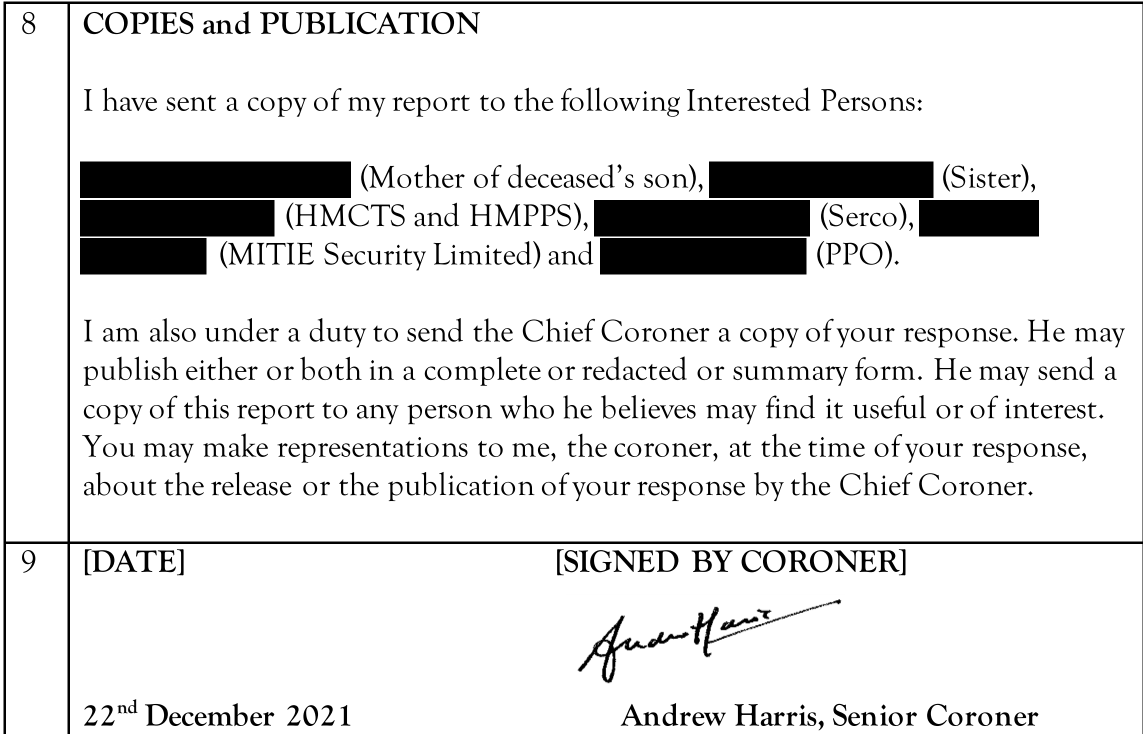
	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO:** 1. [redacted], Second Permanent Secretary, Ministry of Justice and Chief Executive Officer, HM Prison & Probation Service, 102 Petty France, London, SW1H 9AJ
1	**CORONER** I am Andrew Harris, Senior Coroner, London Inner South jurisdiction
2	**CORONER'S LEGAL POWERS** I make this report under paragraph 7, Schedule 5, Coroners and Justice Act 2009 and regulations 28 and 29 of the Coroners (Investigations) Regulations 2013.
3	**INQUEST** On 12th September 2019, an inquest was opened into the death of Mark Castley, (aka Mark Marshall) who died on 26th June 2019 in St Thomas Hospital, (court [redacted]). The inquest was concluded on 8th December 2021. A jury concluded that he died by suicide, by [redacted] which led to his death. It was contributed by non completion of a suicide risk form by probation officer for court staff and non confiscation by the dock officer of his [redacted] which he brought into the dock impermissibly.
4	**CIRCUMSTANCES OF THE DEATH** The probation officer who assessed him when he was on bail, 6 days before his last appearance in court knew that he had a narciccistic personality disorder with a history of impulsive self harm. Indeed he had [redacted] causing a stroke in front of police when they sought to enter his house to arrest him in 2016. She wrote in the OASYS report that his risk of suicide was greatest when police are attempting to arrest him. She did not anticipate that an act of self harm might be repeated when he surrendered bail for sentencing, but acknowledged in retrospect that she would in future consider it a risk. Even if she had she would not have filled out a suicide risk form to notify court staff as she did not consider there was an immediate risk. This appears to have been based on Appendix 1 of the NPS Guide to staff *Working with Suicide*, where the trigger for a stategy to prevent suicide is if the answer to the question *Is there an immediate risk of suicide?* is affirmative. In court she thought perhaps 50% of offenders have suicidal thoughts, but said only about once a month she filled in a suicide risk notification form. She denied she had too high a threshold for assessing imminent risk. .

	Her manager did not consider that the length of sentence would be a surprise to the deceased and informed the court that if the threshold for completing a form was lower, it would catch almost all clients and not enable any priority action. She said that there was nothing in NPS records to indicate the officer should have generated a suicide risk form on 23rd April and that her decision was entirely reasonable and did not consider there was an opportunity to prevent his death as it was not foreseeable. The manager advised that there would be variance between officers as to what was referred but the policy was not too prescriptive to avoid missing some risks. The jury concluded otherwise, identifying the policy as requiring imminence of risk. The dock officer did not know of his past history of impulsive self harm, nor considered there was any risk of self harm or reason to [redacted] It is also evident from that this was a meticulously planned suicide with no indication of intent being disclosed, but from the suicide note, in part related to his having just received another custodial sentence: "*If I die (as) I won't ever be in custody again*".
5	**THE CORONER'S MATTER OF CONCERN** The evidence suggests that his risks of recurrent impulsive self harm in situations his ex wife described as "when he is cornered" were not fully assessed as applying to the time after he was being sentenced and if they had been, a notification form might have been completed. Whether this was due to the policy requiring imminence of risk at the time of assement or being erroneously interpreted so, or whether the projection of imminence arising in a future context was not fully considered, is not clear.
6	**ACTION SHOULD BE TAKEN** In my opinion action should be taken to prevent future deaths. Whilst the precise circumstances of this death were unique and unpredictable, there is a need for public reassurance that the projected contextutal self harm risks of those with personality disorders are recognised and mitigated, especially for those receiving less intensive assessment as they are on bail and not in custody.
7	**YOUR RESPONSE** You are under a duty to respond to this report within 56 days of receiving this report, namely by Wednesday, 16th February 2022. I, the coroner, may extend the period. If you require any further information or assistance about the case, please contact the case officer, [redacted]



8	**COPIES and PUBLICATION** I have sent a copy of my report to the following Interested Persons: ███ (Mother of deceased's son), ███ (Sister), ███ (HMCTS and HMPPS), ███ (Serco), ███ (MITIE Security Limited) and ███ (PPO). I am also under a duty to send the Chief Coroner a copy of your response. He 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	**[DATE]** **[SIGNED BY CORONER]** **22nd December 2021** **Andrew Harris, Senior Coroner**