

ANNEX A

REGULATION 28: REPORT TO PREVENT FUTURE DEATHS (1)

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

	<p>REGULATION 28 REPORT TO PREVENT FUTURE DEATHS</p> <p>THIS REPORT IS BEING SENT TO:</p> <p>HMP Chelmsford Care UK Family Solicitors</p>
1	<p>CORONER</p> <p>I am Caroline Beasley-Murray, senior coroner, for the coroner area of Essex</p>
2	<p>CORONER'S LEGAL POWERS</p> <p>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.</p>
3	<p>INVESTIGATION and INQUEST</p> <p>On 7 September 2015 I commenced an investigation into the death of Warren Martin Sampson. The investigation concluded at the end of the inquest on 2 September 2016. The conclusion of the inquest was that Warren Sampson <i>killed himself</i>. The cause of death was 1a) Suspension</p>
4	<p>CIRCUMSTANCES OF THE DEATH</p> <p>Mr Sampson had been remanded to HM Prison Chelmsford on 3 August 2015. At the time of his death, he was subject to an ACCT – Assessment, care in custody and teamwork. He was found hanging in his cell.</p>
5	<p><u>CORONER'S CONCERNS</u></p> <p>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.</p> <p>The MATTERS OF CONCERN are as follows. –</p> <ol style="list-style-type: none">(1) The “ad hoc” attendance at ACCT reviews of representatives from all disciplines especially Healthcare. The lack of written evidence within the ACCT documentation of contributory input from other agencies such as Healthcare.(2) The lack of a process for following up non- attendance at the Reception Healthcare first night screening(3) The lack of a system for ensuring that all officers are familiar with local directives and instructions
6	<p>ACTION SHOULD BE TAKEN</p> <p>In my opinion action should be taken to prevent future deaths and I believe you and your</p>

	organisation have the power to take such action.
7	<p>YOUR RESPONSE</p> <p>You are under a duty to respond to this report within 56 days of the date of this report, namely by 31st October 2016. I, the coroner, may extend the period.</p> <p>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.</p>
8	<p>COPIES and PUBLICATION</p> <p>I have sent a copy of my report to the Chief Coroner and to the following Interested Persons – solicitors for the family]</p> <p>I am also under a duty to send the Chief Coroner a copy of your response.</p> <p>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.</p>
9	<p>6 September 2015</p> <p style="text-align: right;">Caroline Beasley-Murray</p>