ANNEX A

REGULATION 28: REPORT TO PREVENT FUTURE DEATHS (1)

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

	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO:** **1. Governor, HMP Hewell** **2. Chief Executive, Worcestershire Health and Care NHS Trust** **3. Governor, HMP Bristol**
1	**CORONER** I am Geraint Urias Williams, Senior Coroner, for the coroner area of Worcestershire
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 October 2010 I commenced an investigation into the death of Reggie Johns then aged 58. The investigation concluded at the end of the inquest in the presence of a jury on 11th September 2013. The Jury returned a narrative verdict in the following terms:- "Mr Johns committed suicide. The contributing factors that provided Mr Johns the opportunity to commit suicide were the lack of communication between departments when reviewing Mr Johns ACCT document and deciding to remove him from constant watch without the appropriate input from the relevant qualified persons involved".
4	**CIRCUMSTANCES OF THE DEATH** Mr Johns had been a former life sentence prisoner who was recalled to prison in March 2010 after 18 years in the community. He spent time at HMP Hewell, HMP Long Lartin and HMP Bristol having been moved between establishments because of his behaviour in the prisons concerned. On the 17th October 2010 whilst at HMP Bristol Mr Johns was placed on an ACCT form and was the subject of constant watch because of two separate attempts to hang himself. Previously during his time at Hewell he had been placed on protective measures on not less than 3 occasions and similarly at Bristol on two occasions. Mr Johns was due to appear at Redditch Magistrates Court on 19th October and, because of operational problems, HMP Bristol refused to agree that he should be returned there.

There was limited communication between HMP Bristol and HMP Hewell but ultimately HMP Hewell agreed to accept Mr Johns from Redditch Magistrates court.

Mr Johns appeared at Redditch Magistrates Court and was remanded to HMP Hewell where he arrived in the mid afternoon on the 19th October 2010.

At that stage his constant watch status became apparent to the staff at Hewell.

At Hewell his ACCT status was reviewed by two prison officers who decided not to continue his constant watch status.

He was placed in a cell, where some 6 hours later he was found hanging from a ligature fashioned from a bed sheet.

He was taken to hospital where he died the next day.

Upon arrival at Hewell he underwent a health screen from a female nurse from the Healthcare Department.

That nurse gave evidence saying that she was told that Mr Johns was to be placed in the segregation unit on constant watch. This lead her to conclude that there were no matters which were of concern to her because, as she said very plainly in evidence, everything that could be done for Mr Johns was (insofar as she had been told) going to be done.

That nurse said that although she was aware that an ACCT review was to take place she was not consulted about it, took no part in it and made no contribution towards it.

She said in terms that the two individual prison officers who in fact conducted the review did not at any time speak to her or seek to elicit her view on the matter.

Her view on the matter was that Mr Johns should remain on constant watch to enable him to settle into the prison.

Two prison officers conducted the review. One of those officers left half way through the review leaving Mr Johns in the company of his colleague.

No member of the Healthcare Department or any other member of staff was present at the review.

One of the officers gave evidence to the effect that when he was notified of Mr Johns arrival at the prison he spoke to a member of Healthcare staff who confirmed that there were "no issues" with Mr Johns.

He was however unable to identify even the gender of the person to whom he said he had spoken.

The other prison officer (the one who left the review early) gave evidence to the effect that, having left the review, he spoke to a male member of Healthcare who confirmed that there were "no issues".

The evidence reasonably clearly demonstrated that there was no male member of Healthcare involved with Mr Johns at any stage.

The officer who remained with Mr Johns in the review gave evidence that he knew Mr Johns from his previous time in Hewell, that he believed that they had a good relationship and that he could, therefore, be satisfied that when Mr Johns said he had no intend to harm himself that he could be believed.

	Mr Johns was therefore (with the concurrence of both of the prison officers) placed on normal location rather than in segregation or the Healthcare Department, removed from constant observation because in the opinion of the prison officers there were " no issues" and that the issues which precipitated HMP Bristol placing Mr Johns on constant watch had been dealt with. It appeared from the evidence and was clearly the basis of the jury's conclusion that there was an inadequate review conducted in this case.
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) The extent of communication between HMP Hewell and HMP Bristol was unclear because no written record was kept of discussions held between the respective governors or their staff. Whilst it seems clear that some individuals at Hewell where aware that Mr Johns was on an open ACCT they were not made aware of his constant watch status. (2) Whilst the prison staff were aware of the "then" Prison Service Order 2700 and the requirement to hold a multi disciplinary meeting the reasons which they gave for not doing so were inadequate. It was also of concern that one of the officers left the review after some 10 minutes and there was a significant doubt as to whether in fact either or both of the officers spoke to any member of Healthcare. This when coupled with a lack of formal record keeping as between HMP Hewell and HMP Bristol causes significant concern about the quality of communication between individuals, the robustness of the review process for a prisoner deemed to be a high risk and the involvement of appropriately qualified individuals in the conduct of the review. Although the Treasury Solicitors on behalf of HMP Hewell provided me with confirmation that the present Safer Custody Policy has "effected change" in these matters it remains of concern that the policies at the time (the Prison Service Order in particular) appeared not to be followed. (3) Further concerns involved the failure of the nurse to be provided with the ACCT document when Mr Johns was interviewed by her and her further failure to make any entry within that document detailing her professional view. Put simply there was a concern in the matter that despite the known and understood protocols at the time there was a lack of communication and a lack of sufficiently robust and detailed review of Mr Johns involving all appropriate personnel. Whilst the Safer Custody process has, I am assured, been strengthened those involved should take steps to ensure that all members of staff are fully familiar and trained in the requirements of the policy documents.
6	**ACTION SHOULD BE TAKEN** In my opinion action should be taken to prevent future deaths and I believe you 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 11th November 2013 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: [redacted] I have also sent it to [redacted] (Head of Healthcare HMP Hewell) and The Treasury Solicitors 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	**Signed** ..... **G U Williams** **H M Senior Coroner** **16th day of September 2013**