REGULATION 28: REPORT TO PREVENT FUTURE DEATHS

	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO:** **1. Governor HMYOI Glen Parva** **2. Chief Executive Leicestershire Partnership Trust**
1	**CORONER** I am Lydia Brown, assistant coroner, for the coroner area of Leicester City and Leicestershire South
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 12 June 2014 I commenced an investigation into the death of Greg Revell. The inquest concluded on 17 April 2015. The conclusion of the inquest was "Suicide. Were Greg's individual needs, risks and vulnerabilities appropriately understood, assessed and/or recorded between 9th and 11th June 2014 – No Should Greg have been referred for an assessment by a suitably qualified mental health nurse or doctor on 10th June 2014 – Yes Should an ACCT have been opened on 9th or 10th June 2014 – Yes Should Greg have been placed in a cell with another cell mate between 9th and 11th June 2014 – Yes Is there any fact or circumstance outside prison that you consider to be relevant to the death? – yes, previous attempt at self-harm using a ligature, personal circumstances, inability to deal with life challenges." Cause of death Hanging
4	**CIRCUMSTANCES OF THE DEATH** Found hanging in cell at HM YOI Glen Parva. Resuscitation at scene but unsuccessful. Detailed suicide note left in cell.

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. – **HMYOI Glen Parva** 1. Greg had been in Glen Parva YOI earlier the same year, and on that occasion presented with a florid and undisguisable ligature mark on his neck from an attempt at self harm shortly before his imprisonment. Notwithstanding this, he was not placed on an ACCT. 2. There was confusion amongst Prison Officers who gave evidence regarding when it was appropriate to open an ACCT. 3. There was suggestion that there would be "too many ACCTS" and they would be ineffective if all prisoners with risks were placed on an ACCT. 4. There was over reliance upon what the Prison Officers were told by Greg, and 5. insufficient emphasis on previous recorded risk factors in documentation available to them. 6. There was a culture of over-reliance on "others" being responsible for enquiring further into statements regarding depression and self harm made by Greg, rather than any focus on individual responsibility. **Leicester Partnership Trust** 7. The system for capturing all available healthcare information was insufficiently robust. There was no clear monitoring of obtaining a GP summary promptly to ensure medications and previous medical history could be checked as soon as possible. An opportunity for restarting anti-depressant medication in this case was missed.
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 23 June 2015. 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] (Lester Morrill Solicitors for [redacted] I am also sending a copy to the following who may have an interest in it, and any responses will also be copied to those named below:- Prison and Probation Ombudsman HM Inspector of Prisons Lord Harris (Independent Review into self-inflicted deaths in custody of 19- 8 – 24 year olds)

	National Offender Management Service 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	**28th April 2015** **HMAC Lydia Brown**