REGULATION 28: REPORT TO PREVENT FUTURE DEATHS .

	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO:** • Mr. Andrew Selous, MP, Minister for Prisons. • [redacted], Governing Governor , HMP Manchester • Ms. M. Moran, Chief Executive, MHSC • [redacted], Medical Director , MHSC • [redacted], Greater Manchester Director of Commissioning, NHS England Copied for interest to: • The Chief Coroner • The family of the deceased • The PPO • The Chief Inspector of Prisons • The CSEW • Inquest
1	**CORONER** I am Nigel Sharman Meadows, H.M. Senior Coroner for the area of Manchester City.
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	**INQUEST** On 24th December 2012, I commenced an investigation into the death of Craig Douglas Bell, aged 41. The investigation concluded at the end of the inquest on 27th February 2015. The cause of death was found to be: 1a Hanging The conclusion of the returned by the jury was by reference to the sections on the Record of Inquest as follows: <u>Section 3</u> Craig Douglas Bell took his own life by using a self constructed ligature from his bed sheets which was suspended from the wire mesh on the windows, on 13th December 2012 in cell C4-08 on C wing of HMP Manchester, 1 Southall Street, Manchester. He did so when suffering from a mental disorder; namely a form of personality disorder, but we were unable to determine precisely which one. Craig Bell died some time before 12:20 but after 07:00. He was in an ordinary cell as there were no safer cells available on C wing. No CCTV cells were in use at the time.

	Section 4 Narrative conclusion: Craig Douglas Bell spent long periods of his life within the prison system. Whilst at HMP Manchester in residence on H and K wing Craig was subject to threats and bullying which were proved to be detrimental to Craig's mental state. These issues were not correctly addressed due to inadequate procedures. On several occasions it is documented that Craig would hang himself or end his own life. Craig's level of risk to himself was underestimated, his intentions were clearly stated by himself. The monitoring of Craig over his final few days was inadequate and insufficient. Basic prison procedures were not followed for locking and unlocking on 13th December 2012. ACCT document procedures were not followed in accordance to guidelines within paperwork. Staff were lacking knowledge of Craig's previous mental histories.
4	**CIRCUMSTANCES OF THE DEATH** The above named was born on 7th June 1971 and was found dead in his cell at about 12.20hrs on 13th December 2012 in HM Prison Manchester. His death was reported to me and I authorised a Home Office forensic post mortem examination. I also opened an inquest, which was resumed sitting with a jury on 9th February 2015 and concluded on 27th February. I attach a copy of the Record of Inquest with the jurors' names redacted. The deceased claimed to have been sexually abused as a child over many years. Following this, he came into contact with the criminal justice system and committed a number of offences. This also resulted in him serving several periods of imprisonment. In May 2011 he was arrested after committing a series of offences. He also suffered from substance misuse problems and had a history of self harm and suicidal ideation. He was transferred to HMP Preston, where he was seen by a Forensic Psychiatrist, but no formal diagnostic impression of his mental health was made or recorded. The deceased was managed on an ACCT in HMP Preston since August 2011. He was, however, seen by a Consultant Psychiatrist who prepared a report for the purposes of sentencing. This psychiatrist formed the opinion that the deceased was suffering from an antisocial personality disorder, a post-traumatic stress disorder, a mild depressive disorder and also a substance misuse dependence disorder. He was transferred to HMP Manchester in November 2011 and was subject to ACCT procedures. He was admitted to the Health Care Centre (HCC) and was kept in a safer cell. In April 2012, the ACCT was closed and he was transferred to an ordinary wing location. From about the middle of March 2012, he was voluntarily seeing a psychologist as part of a pilot study in order to reduce the risk of self harm and suicide. His sessions with the psychologist ended on the 5th September 2012. Part of his therapy included cognitive behavioural therapy which he said he found helpful. The psychologist gave evidence and told the court that she regarded his claims of being sexually abused as genuine and that his presentation was entirely consistent with that having occurred. The court also received evidence from the lead Psychologist at the prison who confirmed that a very high proportion of prisoners will suffer from personality disorders or traits of personality disorders. He did work with a team but there was a 5 or 6 month waiting list for patient prisoner to see him. He only worked 1 day a week. However, during the period on ordinary location, he complained of being subject to threats and intimidation and being called a 'grass'. He had been moved from one wing to another. Despite this the appropriate anti social behaviour document was not opened

despite the fact that the identity of one or more of the alleged perpetrators was identified. This did not appear to be accordance with HMPS procedures.

On 6th September 2012 the deceased reported that he had taken an overdose of medication and was admitted to hospital for assessment, tests and observation. He was relatively quickly discharged and initially returned to the HCC. On or about 20th September, he was moved to another ordinary wing location, but discovered that one of the prisoners who had previously been threatening him was now also on that wing.

On 26th September, he disclosed thoughts of active suicidal ideation and immediately was seen and assessed by the wing manager. He was subject to a period of constant observations, in practical terms, before being moved to the HCC again and placed in a safer cell.

He had previously said that he could not successfully harm himself in a safer cell. A particularly unusual feature was that he had no wish to be released from custody and regarded prison as home. Indeed, he described that he felt safe in prison. The Forensic Psychiatrist who carried out a clinical review thought that this was particularly note worthy and not some thing he had encountered in 15 years.

In the HCC, he was subject to a 2 man unlock. Unfortunately the clinical reviewer was unaware of this and only learned the true position when giving evidence at the inquest. This means that the deceased could not be released from his cell unless there were two members of staff available to supervise him at all times. In addition, the other prisoners on the HCC had to be locked in their cells when he was out of his. He had described a serious and severe hatred of paedophiles and that he would attack anyone who he regarded as being one. This also meant that he was spending very considerable amounts of his time in his cell.

On 23rd October, a case conference was held. He had been seen on a number of occasions (by a non-Consultant grade) Psychiatrist who had begun to form the clinical impression that he suffered from a borderline personality disorder. It was felt that there was no clinical justification for him still to remain on the HCC.

He was then seen for the first and only time on the 27 November 2012 by his Consultant Psychiatrist in charge of his care and management in HMP Manchester. This was in conjunction with the other less experienced Psychiatrist. The clinical record confirmed that he was on an unlock protocol in the HCC. During the assessment, he stated that he wants to commit suicide and will do it 'a million percent'. He reiterated his claims of being sexually abused. He had described to a number of psychiatrists since his arrest in May 2009 that he was suffering from hallucinations, but these were not regarded as symptoms of a psychotic disorder, but consistent with some form of personality disorder. He had been prescribed and was taking a modest dose of antidepressant medication and a low dose of Quetiapine, used an anxiolytic and mood stabiliser. The last sentence of the clinical review read: 'To discuss with the Governor on the management of risk once he is transferred outside the Health wing.'

An ACCT had been opened again on 6th September and there had been a number of case reviews (13.9.12, 20.9.12, 26.9.12 x 2, 1.10.12, 8.10.12, 27.10.12, 6.11.12, 20.11.12 and 6.12.12). He had not wished to leave the HCC and had threatened to harm himself should that happen. Following the assessment by the psychiatrist on 27th November 2012, he was not seen again by any Psychiatrist up until and including 6th December 2012. On that day, he had a case review in the HCC, which was not attended by any Psychiatrist, or anyone from the Mental Health In-reach Team. The risk of his self harm or suicide was regarded as raised and the summary of the review said that there had been previous discussions with two previous psychiatrists but there was no clinical reason for him to remain in the HCC. These psychiatric contacts were respectively at the last review in November and involved another Consultant Psychiatrist who only made one clinical entry in late October 2012.

He was meant to see a Psychiatrist within two weeks of his move to an ordinary wing location and that the MHIT was tasked to follow up on him. An MHIT referral was duly made and he was placed on the waiting list. However, by 13th December, he had not seen the Psychiatrist or indeed anybody from the MHIT.

The recording of his ACCT required interactions and observations was far from clear and several witnesses reported different understandings of what the requirements were. It was believed that prior to him leaving the HCC on 6th December 2012, he was occupying a non-safer cell having been moved there from a safer cell after a period of time but it was not possible to determine how long this had been the position. Unfortunately this was another factor the clinical reviewer was unaware of until giving evidence. Upon his transfer to C-wing, the staff there did not know or appreciate that he was regarded as suffering from mental disorder (potentially some form of personality disorder (of what ever type) and also PTSD and a depressive disorder). Furthermore, the Senior Officer who attended this case review did not recall that the deceased had threatened to do something to himself if he were moved although this was clearly documented and another senior Nurse who attended this meeting said that is what happened.

In addition the Senior Officer was unaware of the deceased's direct threat of suicide made on the 27 November 2012 but had she been told this would have prompted her to query if C wing was the right location for the deceased.

It seems that just before his move to C-wing, he was subject to three daily interactions and three nightly observations. C-wing did not have any safer or CCTV monitored cells. He also had a Cell Sharing Risk Assessment which meant he had to occupy a cell alone. Upon his transfer, it appeared that the number of daily interactions increased to 5, and the night time observations were 4. He was only on the wing a few days and kept himself very much to himself. He spent long periods of time in his cell, although he was on the outer part of the wing and could have spent more time out of his cell. He did get a job as a wing painter. No specific officer on duty was allocated to do the ACCT checks during the daytime and on the 8th, 9th and 10th December from about 07.00hrs until midday, there was no recorded checks at all. He was seen before 09.00hrs on 11th, and did attend an ACCT review, which took place later that morning.

A member of the MHIT was contacted by phone, but never attended in person. No Psychiatrist was in attendance, nor any member of the MHIT who had knowledge of him. He presented to the Senior Officer leading the case review as improved. His level of daily interactions appeared to be reduced to 4, from 5. The following day on 12th December, again he was not subject to any checks in the morning from 07.00hrs until midday.

On 13th December, once again there were no checks on him after about 07.00hrs until he was found in his cell at about 12.20hrs. When his cell had been opened up that morning, even though he was subject to ACCT procedures, the officer doing so never went into the cell to check that he was still alive and well. The evidence demonstrated clearly that this should have taken place, and that he should have been subject to one or more contacts during the morning before lunchtime, in view of the fact that he was on an ACCT. The medical evidence established that he died some hours before he was found, and it must have been after his last observation when he was seen in his cell asleep at about 07.00hrs that morning.

The clinical reviewer pointed out that the assessment of risk was a complicated process and that he regarded the deceased as presenting a chronic but fluctuating risk. Events and circumstances could result in the risk being high. The guidance factors included with the standard printed ACCT forms were very far from being the representing the whole assessment . It is not in any sense a tick box exercise. The deceased was being transferred from the HCC where he was stable. He had made direct (at the review on the 27 November 2012) and indirect (at the case review on the 6 December 2012) threats of self harm and suicide if he was moved. He was not willing to do this.

	The clinical reviewer told the court that he had not been sent by those who instructed him a number of significant interviews (5 in total) but he also claimed to have received an interview record from a Nurse whose interview was not included at all as an annex to the final report. On the 9 March 2015 the PPO supplied this extra interview and told the court that it had been omitted in error and this had not been picked up. The clinical reviewer was an experienced practitioner who told the court that in his opinion the risk that the deceased presented had been underestimated at the time of his transfer. Consideration of him being managed on an ordinary wing subject to an ACCT but also with the benefit of using a safer cell and/or a CCTV monitored cell with increased observations and contacts , at least for a period of time would have been appropriate. However , on C wing there were no safer or cells with CCTV monitoring facilities. It required a graduated step down from how he was being cared for on the HCC. It did not seem that there was any interim or half way house from the HCC to an ordinary wing location. The clinical reviewer agreed that there was prevalence of prisoners who suffered from a personality disorder(s) or traits of such. There were very few specific treatment units within the prison system. The court was told that at the time there were only a few safer cells on a very limited number of other wings , including the segregation unit , which would not have been regarded as a suitable location for the ceased in any event. There were a very limited number of cells that had CCTV cameras installed but that following a fatality in 20011 at HMP Manchester (involving Anthony Raymond Gillard whose inquest the court dealt with in late 2014) CCTV monitoring was no longer being carried out as part of any observation regime. The court was told that this was because the HMPS guidance was that if CCTV monitoring was to be used then the cameras had to be continuously monitored 24 hours a day. This was an issue raised by the court following the inquest and coincidentally replies to a formal Regulation 28 PFD report and a letter of concern were received just before the end of the inquest into the death of Mr Bell. The court was told that there was special intervention unit which could house up to 5 prisoners and had a safer cell but this was national facility and not locally controlled and was reserved for those prisoners whose behaviour was quite extreme. The clinical reviewer noted that there was no documented consideration of whether or not the deceased could have been transferred to a mental health hospital or unit outside the HMPS estate for further assessment and/or treatment under the provisions of the Mental Health Act. Whilst it was recognised that this was far from a straight forward procedure it may result in a confirmed or altered diagnosis and a better formulated treatment and management plan.
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: NHS England Commissioners 1. The evidence established a significant unmet need for psychological therapies to treat patient prisoner suffering from personality disorders or those suffering from traits of such personality disorders. These prisoners are recognised as being at higher risk of self harm (which may ultimately result in death) or suicide. Without NHS Commissioners allocating more resources to identifying and treating such patients there is a concern that further prisoners suffering from

these conditions will end up deliberately or accidentally killing themselves.

MHSC and HMPS locally at HMP Manchester

2. I am concerned that the appropriate sharing of information relating to risk and suicidal or self harming behaviour did not take place between the clinical team and HMPS staff. For example, the direct threat of suicide made at the review on the 27 November 2012 was not disclosed to HMPS staff. Appropriate, timely mutual information exchange had not taken place and there is a concern that this may be vital but may be overlooked if steps are not taken to make this a matter of routine. It means that clinical staff have to be able to review the clinical record appropriately and share information with their HMPS colleagues.

3. I am concerned at the lack of attendance of the Consultant Psychiatrist or a suitably qualified and experienced junior colleague at the discharge case review/meeting. In a case of patient still on an ACCT and being discharged to an ordinary wing location without as senior clinician being able to attend and participate in the discharge case review , risk assessment at that stage and risk planning. In this case there was no attendance on the 6 December 2012 and no clinician had seen him since 27 November 2012. This would allow a more sophisticated and timely assessment of risk at that time. Measures to try and reduce or mitigate the risks could then be discussed and put in place in a graduated manner. It is appreciated that such case reviews may have to be rearranged so as to facilitate full attendance. The court has previously identified the concern arising from that fact that no senior clinician took the opportunity at the appropriate time to stand back and take an overall view of the entire circumstances and the risks presented.

4. I am concerned by the lack of planning or consideration of a graduated risk management plan in such circumstances. This was identified by the clinical reviewer. In other words increased frequency of day time interactions and throughout the whole day and MHIT and Psychiatrist contacts very shortly after the move. In this case the deceased was on the waiting list for a MHIT contact and was due to be seen within 2 weeks by the Psychiatrist.

HMPS locally at HMP Manchester and HMPS nationally

5. At the present time the HCC caters for some 22 patient prisoners and has 10 safer cells. I am concerned that the prison has a very limited number of safer cells on a limited number of other wings. At the present time there are no safer cells on all the wings (invariably single occupancy designed to minimise the risk of using ligatures). If prisoners are subject to ACCT's and either transferred from one wing to another or transferred from the HCC to an ordinary wing location (for what ever reason) there is no half way house facility providing increased levels of safety. The provision of safer cells has demonstrably reduced the opportunity for fatal self harming in the over whelming majority of cases. Without HMPS investing in the provision of safer cells on every wing or an increased number of wings there is a concern that prisoners will continue to kill themselves in non safer cells when they are on ACCT's. The same considerations would apply nationally to the entire HMPS estate.

6. In 2011 there were a limited number of cells which had been fitted with CCTV monitoring cameras. Very sadly Anthony Raymond Gillard was found dead in such a cell on the 24 December 2011 but that the use of CCTV was not part of his observation regime although he was subject to ACCT procedures. No one looked at or considered the CCTV pictures until after his death but they clearly demonstrated that he had been suffering the effects of over sedation from opiate drugs which no witness had seen or noticed. The use of CCTV monitored cells was discontinued after his death and was not available at the time of Mr Bell's death. One reason given was that if they were used it required a Prison Officer

	to be monitoring the CCTV images constantly 24 hours a day. They could , of course , be used as an adjunct or in addition to usual ACCT observation procedures. This would not require constant CCTV monitoring. NOMS have replied to the court's Regulation 28 PFD report and a copy is attached. I am concerned that if such cells/facilities are not provided and used then there is a risk that prisoners on ACCT's will continue to be able to kill themselves. The same considerations would apply nationally to the entire HMPS estate. I attach copies of the NOMS response to my Regulation 28 PFD and letter under paragraphs 37/38 of the Chief Coroner's guidance in relation to Mr Gillard's death.
6	**ACTION SHOULD BE TAKEN** In my opinion action should be taken to prevent future deaths and I believe you and 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 Monday 11 May 2015. This is slightly longer than 56 days because of the Easter Bank holidays 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 Interested Persons. I have also sent it to organisations 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	**9 March 2015**  **Nigel S. Meadows** **H.M. Senior Coroner** **Manchester City area**