REGULATION 28: REPORT TO PREVENT FUTURE DEATHS

	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO:** **1. NHS England** **2. Secretary of State for Health**
1	**CORONER** I am Nicholas Rheinberg senior coroner for the coroner area of Cheshire
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 23rd May 2014 I commenced an investigation into the death of Kevin Dermott born on 29th September 1963. The investigation concluded at the end of the inquest commencing on 23rd May 2016 and concluding on 7th June 2016. The conclusion of the inquest was that at some time between 19.00 and 20.43 on Monday 19th May 2014, the deceased hanged himself using a ligature attached to his bed in his cell on landing 3 at HMP Risley. The following matters contributed to his death namely, failure to procure adequate medical care, uphold adequate channels of communication and to follow the ACCT process according to its procedures.
4	**CIRCUMSTANCES OF THE DEATH** The deceased who had been diagnosed with bi-polar affective disorder was sentenced to a term of imprisonment. Whilst a prisoner at HMP Durham he suffered a severe hypomanic episode. Having been transferred to HMP Haverigg and then HMP Kirkham, he was sent to HMP Risley where, during a probable relapse in his condition into a depressive episode, he hanged himself.
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. – The seriousness of the deceased's condition was realised whilst the deceased was at HMP Durham although probably initially misdiagnosed. During a hypomanic episode which lasted a number of weeks the deceased was for a time left in a urine soaked cell, drinking and washing from the cell toilet at a time when he needed specialist hospital treatment. The evidence showed that his illness was not properly addressed. At HMP Durham a psychiatric referral for the purpose of compiling a care plan, including a plan for therapeutic medication was never completed and he was transferred to HMP Haverigg without any steps being taken to plan health care for the future, take action to avoid a recurrence of his illness or identify and deal with a relapse should one occur. At HMP Haverigg there was inadequate mental health cover with at times only one mental

	health nurse and no provision for psychiatric referral. He was transferred to HMP Kirkham. A lack of suitable psychiatric care facilities at HMP Kirkham (among other things) led to a transfer to HMP Risley, where due to inadequacies of care planning and communication deficits which had been a feature of the deceased's care whilst in prison, the fact that the deceased was relapsing into depression was not recognised. The jury concluded that the deceased's death by hanging was partly due to deficiencies in mental health care and failure to properly observe ACCT procedures.
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. Evidence at the inquest emerged that up to 80% of prisoners have some mental health problem but that mental health facilities in prison were not adequate sufficiently to address mental illnesses such as the deceased suffered. In particular there was seen to be inadequate consultant psychiatric support, lack of long-term care planning, lack of continuity of care and lack of hospital facilities to deal with acute psychiatric problems. Such facilities as existed were seen to be inferior to the care which a mentally ill patient would receive in the community. The problem was seen as running through the prison service as a whole rather than an isolated problem within one prison establishment and was seen as justifying a fundamental review of mental health provision within the prison service.
7	**YOUR RESPONSE** You are under a duty to respond to this report within 56 days of the date of this report, namely by 10th August 2016. 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 namely the family of the deceased, the Treasury Solicitor on behalf of HMPs Durham, Haverigg, Kirkham and Risley and the mental health providers of the four prisons. 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	**Dated this 13th Day of June 2016** **SIGNED BY CORONER**