REGULATION 28: REPORT TO PREVENT FUTURE DEATHS

	THIS REPORT IS BEING SENT TO: **1. The Rt Hon Elizabeth Truss MP, Secretary of State for Justice.** **2. Michael Spurr, Director General of the National Offender Management Service.**
1	**CORONER** I am Caroline Sarah Sumeray, Senior Coroner for the Coroner Area of the Isle of Wight.
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 4th November 2013 I commenced an investigation into the death of Stephen St Clair, aged 52. The investigation concluded at the end of the inquest on 12th July 2016. The conclusion of the inquest was "Open Conclusion. At the time of death, the deceased suffered from undiagnosed mental illness, the risks of which were not evident to personnel that were not medically trained." The medical cause of death was found to be: 1a Exsanguination 1b Incision Wound of the Neck.
4	**CIRCUMSTANCES OF THE DEATH** 1) Stephen Bucouski was born on 22nd December 1960 in Widnes in Cheshire. He changed his name a few years before he died to Stephen St Clair. At the time of his death, he was 52 years of age. 2) On 17th August 2012, he was sentenced to a term of 14 years imprisonment. He initially started to serve this sentence at a prison on the mainland and was transferred to HMP Isle of Wight on 31st July 2013. 3) Mr St Clair was reported to have been a quiet man who spent most of his free time reading in his cell and did not mix much with other prisoners. On 20th August 2013, Mr St Clair put his concerns about his safety in writing to his Wing Officers. He said that he had heard other prisoners, whose identity he did not

know, mentioning his name and threatening violence. Mr St Clair's Personal Officer told him that they needed more information about the other prisoners before anything could be done. A Security Information Report (SIR) was completed to document Mr St Clair's concerns, but it appears that there was no further investigation or action taken at that stage.

4) On 21st October 2013, Mr St Clair made a formal complaint that he was not being protected from other prisoners' aggressive and threatening conversations about him and that this was affecting his mental wellbeing. As part of the response, a Supervising Officer (SO) and a Wing Officer discussed his concerns with him, but were unable to find any evidence of threats being made. In a written response, outlining what they had agreed they could do to help him, the SO indicated that a Mental Health Referral might help Mr St Clair with his anxieties, but the SO did not make a referral at that point.

5) On Saturday 2nd November, Mr St Clair spoke to the SO and another Wing Officer about the written response that he had received to his complaint. He handed the 2 Prison Officers a handwritten 2-sided piece of A4 paper with a series of paranoid entries, apparently written within the previous 24 hours, giving considerable insight into his state of mind. During the conversation, the Prison Officers decided that a Mental Health Referral was necessary and made one that day, but it was not due to be received by the Mental Health Inreach Team until the following Monday, 4th November, and was received by them after Mr St Clair's death. The Prison Officers considered whether Mr St Clair might be suicidal, but Mr St Clair said that he had no thoughts of killing himself.

6) Mr St Clair's cellmate told the Prisons and Probation Ombudsman Investigator that Mr St Clair had seemed frightened and paranoid for some weeks, but he had seen no evidence that other prisoners were threatening him. He reported that, on 2nd November 2013, Mr St Clair appeared to be very anxious, was awake a lot at night and paced up and down the cell. He said that he didn't want to eat anything, even when his cellmate brought his meals to the cell. On Sunday 3rd November 2013, Mr St Clair's cellmate told staff that he felt that he could no longer support Mr St Clair and did not want to share a cell with him any longer.

7) Mr St Clair was moved to a single cell on another Wing on the afternoon of 3rd November 2013. Prison Staff on his new Wing were unaware of the reasons for Mr St Clair's relocation, beyond a vaguely phrased "paranoia" with no further details given. No further consideration was given to whether he was at risk of suicide or self-harm and needed additional support and monitoring. At no stage

	was an ACCT opened in respect of Mr St Clair on the basis that the Prison Officers did not believe that he was at risk of self-harm or suicide. 8) On Monday 4th November 2013, at a routine early morning roll check, Mr St Clair was found in his cell with a severe cut to his throat. Although there were signs that he had already died, Prison Staff tried to resuscitate Mr St Clair, until paramedics arrived and pronounced his death at 05.55 hours. 9) Expert evidence heard at the Inquest from a Consultant Forensic Psychiatrist indicated that there was clear evidence of paranoia and psychosis in the note given to the Prison Officers, and this paranoia and irrational thinking was further evidenced in earlier conversations with both Prison Officers, Prison Staff and his cellmate.
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 Prison Service Instruction ("PSI") 64/2011 (*Management of prisoners at risk of harm to self, to others and from others (Safer Custody)*" addresses the "Risk Factors for Suicide". There are various subheadings, including "Clinical History" where the following point is made: "Mental illness diagnosis (e.g. depression, bipolar disorder, schizophrenia)" but there is no description of the possible symptoms which might be displayed by those who may be suffering from as yet undiagnosed conditions. 2. The next section in PSI 64/2011 deals with "Risk Factors for Self-Harm" and includes a sub-heading entitled "Current Context" where the following is included: "Irrational behaviour, out of touch with reality". 3. I am concerned that the "Risk Factors for Suicide" does not actually include words to the effect of "Irrational behaviour, out of touch with reality" as the evidence from the Consultant Forensic Psychiatrist suggested that this behaviour was strongly suggestive of psychosis, and as such, the prisoner was in need of additional monitoring to keep him safe and to protect him from self-harm or suicide. 4. I am concerned that as this additional wording was not included in PSI 64/2011, the Prison Officers did not feel obligated to open an ACCT document, which

	may have resulted in Mr St Clair being monitored more closely, thereby avoiding him taking his own life.
6	**ACTION SHOULD BE TAKEN** In my opinion action should be taken to prevent future deaths and I believe you and/or 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 6th October 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: the family of Stephen St Clair; Care UK; Peter Clarke CVO OBE QPM, HM Chief Inspector of Prisons and Andy Lattimore, Governing Governor of HMP Isle of Wight. 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	 **H.M. Senior Coroner – Isle of Wight** **12th August 2016**