G A Short
Senior Coroner for Central Hampshire

	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS THIS REPORT IS BEING SENT TO: HM Prison Service and The Samaritans
1	**CORONER** I am G A Short, Senior Coroner for Central Hampshire
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. http://www.legislation.gov.uk/ukpga/2009/25/schedule/5/paragraph/7 http://www.legislation.gov.uk/uksi/2013/1629/part/7/made
3	**INVESTIGATION and INQUEST** On 20 July 2015 I commenced an investigation into the death of Haydn James Burton, 42. The investigation concluded at the end of the inquest on 27 September 2016. The conclusion of the inquest was that Haydn Burton died as a result of hanging in his prison cell at HMP Winchester. The jury recorded that his mental state at the time was unclear and that it was not possible to rule out an impulsive act as part of his personality disorder or as a means to bring attention to his perceived plight. This event was exacerbated by an inadequate implementation of ACCT policies and by insufficient communication between the various elements of the prison system.
4	**CIRCUMSTANCES OF THE DEATH** Haydn Burton was detained in HMP Winchester as a convicted prisoner and had been made subject to an ACCT order at 09.30 on 14 July 2015. He was found at 10.00 in the morning of 15 July 2015 having suspended himself from a ligature point in his cell (B3.30). Prison Officers, healthcare staff and ambulance staff resuscitated Mr Burton and he was transferred to Royal Hampshire County Hospital, Winchester where he died of the delayed effects of ligature suspension on 18 July 2015.
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 evidence in this case indicated that prison staff at Winchester Prison are not implementing ACCT plans in accordance with national policy notwithstanding the training they have received and in particular the observations conducted are inadequate. I therefore consider that the process and future training needs to be reviewed (2) The Prison Listener scheme rules as to prisoner confidentiality appeared to be confusing to the listener involved in this case. The HMP Winchester Listener Scheme Protocol dated October 2012 makes no reference to situations where an "at risk" prisoner admits to having made active plans for suicide and threatens to self harm in the future (as in this case). I consider the protocol for Listeners should make it another exception to the principle of confidentiality so that they can pass such information to prison staff and that Listeners should be trained to do so if they have reason to believe there is an imminent risk of suicide even if the prisoner is already subject to an ACCT.

(3) The case highlighted the limitations of the NOMIS database in relation to recording details of closed ACCT plans meaning that prison staff are frequently unaware of important information about individuals gathered previously. The case showed that despite the national policy requiring Case Notes to be made of all ACCT plans this does not happen for all prisoners so that staff are ignorant even of the fact that there was a previous ACCT in place let alone the reason for it. The ACCT post-closure process should therefore be reviewed. I consider this is particularly relevant where an ACCT is closed and the prisoner is later released and then re-imprisoned or is transferred to a different establishment.

6 ACTION SHOULD BE TAKEN

In my opinion action should be taken to prevent future deaths and I believe you HM Prison Service and (in relation to (2) only) The Samaritans 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 30 November 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

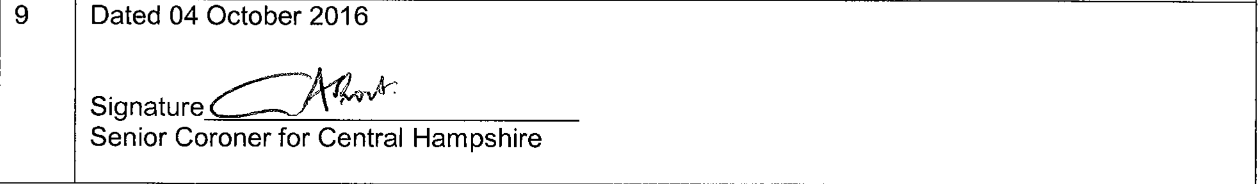
I have sent a copy of my report to the Chief Coroner and to the following Interested Persons:

- [redacted]
- Central and North West London NHS Foundation Trust

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 04 October 2016



Signature

Senior Coroner for Central Hampshire

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