IN THE SURREY CORONER'S COURT
IN THE MATTER OF:

The Inquest Touching the Death of
Matthew RUSSELL
A Regulation 28 Report – Action to Prevent Future Deaths

	THIS REPORT IS BEING SENT TO: • The Rt Hon. Elizabeth Truss MP, Secretary of State for Justice. • [redacted] – Governor HM Prison High Down. • [redacted] – Chair of Central and North West London NHS Foundation Trust
1	**CORONER** Richard Travers HM Senior Coroner for the County of Surrey
2	**CORONER'S LEGAL POWERS** I make this report under paragraph 7(1) of Schedule 5 to The Coroners and Justice Act 2009.
3	**INVESTIGATION and INQUEST** The inquest into the death of **Matthew RUSSELL** was opened on the 15th April 2015 and was resumed with a jury on the 31st October 2016. The jury returned their conclusion on the 17th November 2016, having been in retirement for ten hours and eighteen minutes. They found the medical cause of death to have been: 1a. Hanging. They concluded with a narrative verdict and a short form conclusion of suicide.
4	**CIRCUMSTANCES OF THE DEATH** At the date of his death on the 6th April 2015, Mr Russell was a serving prisoner, having been sentenced to a term of imprisonment of 16 years in January of that year. He arrived at HMP High Down on the 5th December 2014, following conviction at the Crown Court siting at Croydon and was immediately placed on an ACCT document and referred to the In-Reach

	team for psychiatric assessment. On 10th December 2014 he was assessed by a GP as suffering from severe depression and was prescribed anti-depressant medication by that same GP. That medication was the subject of repeat prescriptions up to the date of his death with no review. The first ACCT document was closed later in December 2014 and Mr Russell was discharged from the care of In-Reach on the 8th January 2015. A further ACCT document was opened on the 17th February 2015 and this ACCT document remained at the date of his death. Mr Russell had been diagnosed with ADHD and Dyspraxia at the age of twelve. He had a history of depression and self-harm and during his time at HMP High Down he had self-harmed on a number of occasions and had been found, also on a number of occasions, with a ligature around his neck. Whilst on the second ACCT document he had been the subject of eight case reviews, but none of them had been multidisciplinary. At or about 19.10 hours on the 5th April 2015, he was found hanging by a ligature from the hinge of his cell door. CPR was preformed and he was transferred to St George's Hospital, Tooting, where he died the following day. The jury concluded that there were multiple failures in the management and application of the ACCT plan procedure which materially contributed to Mr Russell's death.
5	**CORONER'S CONCERNS** During the course of the inquest the evidence revealed matters giving rise to concern. Whilst Central and North West London NHS Foundation Trust were not responsible for the provision of the In-Reach care at the time of Mr Russell's death, they took over that responsibility shortly after his death and, in the absence of the jury, I heard evidence from an employee of the Trust about the current situation at HMP High Down. In my opinion, on the basis of all the evidence that I heard in this inquest, 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: Central and North West London Foundation Trust a. The proper and regular monitoring of all medication that is prescribed by way of a repeat prescription. b. The preparation of structured care plans for each patient. c. An effective procedure for following up patients who fail to attend pre-booked appointments with clinicians. d. The effective use of Read Codes on the System One record, to flag up and highlight significant risk factors in a patient's care.

	e. Ensuring that all staff with responsibility for patients in prison have received adequate foundation training and on-going training in the ACCT procedure. f. Ensuring that caseworkers are aware of and attend ACCT Case Reviews for patients under their care. g. Ensuring that there is regular effective communication about a patient's needs with the GPs and the primary healthcare practitioners at HMP High Down. HM Prison High Down a. Ensuring that all staff have received adequate foundation and on-going training in the ACCT procedure, with particular emphasis on: • Requiring ACCT Case Reviews to be multidisciplinary and thereby ensuring that all relevant medical practitioners are aware of the date and time of any such review and have been invited to attend. • Risk Assessments in relation to individual prisoners. b. Ensuring that all Gate House staff understand the proper procedure to adopt when receiving a call from a prisoner's family or friends expressing concerns for that prisoner's safety or wellbeing.
	ACTION SHOULD BE TAKEN In my opinion action should be taken to prevent future deaths and I believe that you, the persons listed in paragraph one above, have the power to take such action.
7	**YOUR RESPONSE** You are under a duty to respond to this report within 56 days of its date; I may extend that period on request. Your response must contain details of action taken or proposed to be taken, setting out the timetable for such action. Otherwise you must explain why no action is proposed.
8	**COPIES and PUBLICATION** I have sent a copy of this report to the following: 1. The Rt Hon. Elizabeth Truss MP, Secretary of State for Justice. 2. [redacted] – Governor HM Prison High Down. 3. [redacted] – Chair of Central and North West

	London NHS Foundation Trust. 4. Hodge, Jones & Allen (on behalf of the family) 5. Gvt Legal Dept (on behalf of HMP High Down) 6. Bevan Britton (on behalf of the Virgin Care) 7. Hill Dickinson (on behalf of the Surrey and Borders NHS Foundation Trust) 8. RLB Law (on behalf of Central and North West London NHS Foundation Trust) 9. The Chief Coroner In addition to this report, I am 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 Senior Coroner, at the time of your response, about the release or the publication of your response by the Chief Coroner.
	Signed: Richard Travers **DATED this 27th November 2016**