	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS THIS REPORT IS BEING SENT TO: 1. Lord Chancellor and Secretary of State for Justice, The Rt. Hon Liz Truss, Ministry of Justice, 102 Petty France, London, SW1H 9AJ 2. Home Secretary, The Rt. Hon Amber Rudd, House of Commons, London SW1A 0AA 3. The Secretary of State for Health, Rt. Hon Jeremy Hunt, Richmond House, 79 Whitehall, London SW1A 2NS 4. Those who performed the Mental Health Act [redacted] DAC Beachcroft LLP, 100 Fetter Lane, London, EC4A 1BN and Head of Legal Services, Hampshire County Council, Corporate Services, R22, E11 South, The Castle, Winchester 5. [redacted] Virgin Health Care Limited
1	CORONER I am Dr Andrew Harris, Senior Coroner, London Inner South jurisdiction
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 22nd July 2015, I commenced an investigation and on 24th July I opened an inquest into the death of **Richard Walsh, who died on 19th July 2015 in HMP Belmarsh, Western Way, Thamesmead, London; Case Ref: 01936 -15 (JB).** It was concluded on 27th September 2016. The jury concluded in a narrative conclusion that he came by his death by suicide. They returned a finding that omissions in a Mental Health Act Assessment after his arrest and detention in a police station, before transfer to prison, amounted to Neglect on four counts: Failure of both psychiatrists and of the Approved Mental Health Act Practitioner to seek clinical information, Failure to admit to hospital under MHA section, and Failure to conduct an adequate Mental Health Act Assessment. The jury concluded that he would not have died when he did if he had been "sectioned".
4	CIRCUMSTANCES OF THE DEATH An expert psychiatrist gave evidence, having considered his behaviour of unprovoked stabbing of 2 boys, his delusions, hiding under a blanket in the police station, his obsession with a police woman, his outburst in prison, and study of a previous admission under mental health care that he suffered from De Clerambault syndrome (erotomania) and was suffering psychosis. After arrest and

	charged with attempted murder, the deceased had delusions and refused to drink or eat for 48 hours with a stated intention to police officers that he would thus die on the 3rd day. He was remanded to HMP Highdown, where he was segregated; transferred to HMP Belmarsh 3 days later, where he was isolated in a single cell, for his protection, for 23 ½ hours a day, where he hung himself after 17 days.
5	**CORONER'S CONCERNS** During the course of the inquest, the evidence revealed a matter giving rise to concern that in my opinion means that there is still 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 expert psychiatrist gave an opinion that there was a defect in the system of communications between professionals and agencies involved in the care of Mr Walsh. There appeared to be not only serious failures of communication, but failures from inadequate processes of communication between custodial and health professionals, between police, court, health care and prison services, that progressively lost crucial information about the risks and needs of the deceased as he passed through different hands. The expert described what staff knew at HMP Belmarsh as diluted and grossly distorted. Evidence heard is listed: a) Those conducting the MHA assessment did not discover that, on the very evening of the assessment, the police had been in contact with the deceased mother, who had key information about his mental health, nor did examine the custody record or log, nor consult the Detained Persons Medical Forms, which one described as usually containing little useful information. The Custody officers and MHA assessors never spoke. b) The AMHP said that the Mental Health Act (MHA) assessment was put on RIO system for Hampshire NHS staff, and could be made available to general practice or prison healthcare on request, but was not automatically transferred. There was a need for a national process of information sharing. c) The Custody Advisor informs the court that the national system was that the Detained Person's Medical Forms (DPMFs) were routinely scanned onto the police RMS system, but the Mental Health Act Assessment is not. The logic was not apparent, as both would appear to have the same quality of confidence. d) Medical in confidence information from police stations was sometimes transmitted in sealed envelopes marked *Confidential*, travelling with the prisoner, but the independent psychiatric expert thought that this was the least effective form of communication and recommended that the assessing team should communicate with the next stage in the process, such as contacting the catchment area forensic service by phone out of hours, advising that the prisoner is likely to go to a particular court, and writing a letter with the assessment in office hours. The Police Custody Advisor said that he would not expect the Mental Health Act

Assessment report to routinely go to the court or prisons with the Prisoner Escort Record (PER), unless the prisoner was sectioned. The logic for this was also not clear, as the non sectioned patient was more at risk of not having appropriate mental health care from non communication, than the sectioned one.

e) No report or letter or appropriate communication about the MHA assessment was completed in the police station to subsequent health care providers, nor was there a system to require it.

f) There was no evidence that the police doctor (FME) and police nurses notes, called Detained Person's Medical Forms (DPMFs) were ever seen by anyone with responsibility for Mr Walsh in Highdown or Belmarsh prisons, nor evidence of any established process of transfer of the information. Prison staff said that medical in confidence information can be scanned to prison health care, but there was not an established system of securing medical records from police stations.

g) The Pre-Release risk assessment was completed by a custody officer, indicating that the deceased had no risks. The Custody Advisor indicated that the officer did not appear to understand the system, as this particular questionnaire in the custody record should not have been completed for transfer to court. But it appeared that its negative entries may have misled others assessing risk at time of transfer.

h) The completion of the PER in the police station did not reflect the contents of the custody record or custody log, failing to record his attempt to commit suicide by dehydration, his delusions, his obsession, or that he had been assessed as high risk of suicide. The Custody Advisor said that the system was meant to be that the PER was signed off by the custody officer, who should have known that the information was incorrect.

i) The police staff completing the PER indicated she routinely did this without consultation with the custody log or custody record, which was not required, although the Custody Advisor informed the court that this was not meant to be the system.

j) The care plan at the police station which was recorded in detail in the custody record (and is meant to record any risks and evidence of mental illness) was not sent onwards with the PER, nor was the section on the PER marked Care Plan completed, as the Custody Advisor informed it should be. Staff informed the court it never is.

k) Staff at the first night centre assessment at HMP Highdown saw the basic information about his offence and recent history and the police national computer printout with no markers, although a subsequent one was found with markers, indicating a previous attempt in custody to hang himself in custody and a threat to stab anyone who takes his children. There was no explanation for a false negative being sent.

l) It is not clear if the nurse doing the health screen at HMP Highdown was shown or looked at the PER from the police station.

m) It is not clear whether the nurse assessing health fitness for segregation in HMP Highdown by completing a proforma, did consult the System One Medical Records, but the nurse agreed that he had no information on the prisoner's behaviour and health in the police station, nor over the preceding four weeks, which he needed, and that he expected the reception nurse to bring information to him and it was not for him to go to Reception to get it.

n) The PER completed at HMP Highdown did not even reflect the limited information they had received from the police station three days earlier. It recorded no current health risks although the previous PER from the police station had indicated non compliance with MHA assessment and depression, a GP letter received reported a previous overdose in February and the decision had been made in reception that he needed mental health in reach service. The health care officer just recorded "fit for transfer".

o) The prison officer conducting the first night centre assessment in HMP Belmarsh did not see or consider the PER from police station to HMP Highdown, three days previously. He did know he had a serious charge coming up for sentence and had no family support and was going to be isolated for 23 ½ hours a day in a single cell. He did not know he was depressed and on antidepressants, and if he had he would have opened an ACTT. Yet this information was known to health care staff. He reports that the nurse told him of no concerns and he told her of none.

p) It was not apparent that the first night nurse assessment in HMP Belmarsh knew of or included consideration of his status on a "duty care regime", which isolated him for his protection from other inmates. The nurse did not feel there was time nor was it his job to review the medical records. He completed his proforma recording what the prisoner replied, even though he had information that it may be untrue and did not regard it was his job to record or reconcile differences.

q) The reception GP assessment in HMP Belmarsh did not consider his status isolated on a "duty care regime", although agreed it was risk factor, nor had any knowledge of his behaviour in the police station or see any relevant information from PNomis or discipline staff.

r) The GP doing the GP assessment in HMP Belmarsh informed the court that there was insufficient time in his job to review the inmate medical records. He agreed that the records showed that suicide six risk factors listed in *Early Days in Custody* were present – recent change in circumstance, transfer another establishment, violent offence, history self harm and suicide, potentially category

A and history of mental illness and drug or alcohol problems. He had neither been informed of these factors nor identified them from the records and so neither opened an ACCT nor referred him to a psychiatrist.

s) He was referred to the MH in-reach team by the nurse. That team reviewed his medical records, showing a history of alcohol abuse and depression on treatment (which did not apparently include any from the police station, which the psychiatrist said he does not routinely see) and were reassured by his not being followed up by a psychiatrist in the community after a previous psychiatric admission, and by his presentation not raising any concerns for almost all the doctors and nurses, who had seen him in prisons. They did not see any PERs, and was not informed he was being isolated in a "duty of care regime " for 23 ½ hours a day, nor that the victims were children. The decision not to conduct a psychiatric assessment would have been different if he had seen the PERs or DPMFs or MHA assessment, or his in patient psychiatric notes.

t) The independent psychiatrist gave an opinion that the loss of key information was a particular concern as people move in and out of custody so that there was a potential that information would be lost to the civilian GP.

Whilst some organizations had taken a number of steps to minimize the risks to the lives of others, particular the development of a national PER, others had only awoken to the risks in the closing days of the inquest. Virgin Health Care chose not to attend, Southern Health and Oxleas NHS Trust submitted plans to prevent future deaths before the inquest concluded. Hampshire Constabulary reported changes in training and staff awareness. Hampshire County Council prepared a short document of proposed actions, but it was not available as evidence as it was received by the court after the conclusion of the evidence. The evidence taken as a whole, suggested that there was a breakdown of communication at every professional and organizational interface, 18 of which are illustrated above. There was no agreed system for transfer of health care information from police station court, or from either to prison. There was no functioning and consistent system of passing risk information from one detained organization to another. There was not agreement whether there just was a duty to pass the information or it if it was not in possession, whether there was also one to ask for it and if so which individual bore that responsibility. There appeared to be a focus by individuals on completing the proforma or questionnaire required by the system, by rote with either no time to consider the whole person, or no sense that it was their responsibility to consider missing or discordant information or to be proactive in communicating gaps in knowledge or concerns. From the evidence of a number of witnesses, the pattern of communication was not exceptional in this instance but reflected what usually happened.

2. That the standard of Mental Health Act assessments by these individuals needs to be improved, and, given all three were in complete agreement, that also training and provision for MHA assessments in police stations more widely may need to be reviewed.

	3. That the inadequacy of the nurse assessment of fitness for segregation in HMP Highdown (see m) above) is a risk. [redacted] was not ACCT trained and it appeared that he was unaware of PSI 1700. The inadequacy may reflect individual or wider weaknesses in assessment or choice of assessors that mean that prisoners go to segregation when they should be in the health care wing, or that they go without observation, when they should be on an ACCT and receive extra support.
6	ACTION SHOULD BE TAKEN In my opinion action should be taken to prevent future deaths. I believe that the following organizations or individuals have the power to take such action. 1. The Secretaries of State of Home Office, Health and Ministry of Justice are notified of Matter no.1, the apparent defects in the system of communication. They are asked to consider not only the adequacy of the instant organization's response, but whether there is a need to consider the risks are more appropriately addressed nationally. 2. In view of the conclusion of the jury with regard to neglect, the following are notified of Matter no. 2 about the adequacy and safety of MHA assessments. a) [redacted] are asked to consider whether they should refer themselves to their professional body, as has their colleague, [redacted] b) The Department of Health is also asked to draw to the attention of those leading the Departmental Training programme for AMHPs the circumstances and findings of this inquest and consider whether further guidance or training with regard to the performance of Mental Health Act Assessments is required. 3. Virgin Health Care is notified of Matter no. 3, the weaknesses and lack of training admitted by their nurse in conducting the fitness for segregation assessment and asked to consider whether the process is fit for purpose or whether redesign or further training is indicated.
7	YOUR RESPONSE You are under a duty to respond to this report within 56 days of the date of this report, namely by Tuesday December 20th 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. If you require any further information or assistance about the case, please contact the case officer, [redacted]

8	COPIES and PUBLICATION I have sent a copy of my report to the following Interested Persons: [redacted] of Hickman and Rose Solicitors for the family, Government Legal for HMP Belmarsh, Capsticks Solicitors for Oxleas, Thompsons Solicitors for Prison Officers Association, [redacted], Virgin Health Care, Hampshire Police, DAC Beachcroft for [redacted] and Stephen Fidler Solicitors for [redacted] Medical Protection Society. I have also sent it to The Royal College of Psychiatrists and [redacted] independent psychiatric expert, who may find it useful or of interest. The court is happy to provide further documentation to the College or to Ministers, if it would assist in their deliberations. I am also under a duty to send a copy to the Chief Coroner as well as 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	[DATE] 25-10-16 [SIGNED BY CORONER]