ANNEX A

REGULATION 28: REPORT TO PREVENT FUTURE DEATHS (1)

*NOTE: This form is to be used **after** an inquest.*

	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO:** **Her Majesty's Prison Service** **Care UK Clinical Services** **South Essex Partnership Trust** **NHS England**
1	**CORONER** I am Caroline Beasley-Murray, senior coroner, for the coroner area of Essex
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 5 January 2016 I commenced an investigation into the death of Dean Gary Saunders. The investigation concluded at the end of the inquest on 20 January 2017. The conclusion of the inquest was:- *Dean Gary Saunders killed himself whilst the balance of his mind was disturbed and the cause of death was contributed to by neglect.* The jury provided in addition the following Narrative conclusion:-. *This has been an extremely challenging case; the jury would first like to express its sincere condolences to Dean's family.* *We believe that a number of serious failings led to Dean's death and we set out these as follows. There is no particular significance to the order in which we present them.* *The mental health assessment at Basildon police station was not adequate due to a failure to pass information pertinent to Dean's then mental state and its consequent risks. The delay in carrying out the assessment contributed to this serious failing.* *While we do not believe that the result of the assessment itself was predetermined, the pathway to prison was.* *On the balance of limited evidence and lack of a proper audit trail we are unable to conclude whether sufficient enquiries were made into the availability of beds out of area or privately. The only certainty is that a bed at Brockfield House was*

only available on 4th January 2016.

It was clear Dean was in need of a place of safety, as such his route from Basildon police station to prison was the only available option.

In our view the ACCT assessment on 21st December 2015 was not adequately conducted for the following reasons:

- *No medical or mental health professional attended the assessment;*
- *The assessment did not have sufficient multi-disciplinary attendance;*
- *The head of healthcare had, to a very large extent, predetermined that the result of the assessment would be the removal of constant watch;*
- *The head of healthcare treated financial considerations as a significant reason to reduce the level of observations;*
- *The attendees at the assessment failed to review sufficient background information prior to the assessment, including full and detailed knowledge of key events such as the plastic bag incident, which had taken place moments before the ACCT review;*
- *The assessment was held prior to the completion of the psychiatrist's assessment.*

HMP Chelmsford's response to the family in general and on 23rd December 2015 in particular was inadequate.

These include but are not limited to basic administrative errors, such as a failure to record and pass on telephone numbers, failure to record all information, failure to initiate usage of the phone PIN system, and no consideration of family attendance at ACCT assessments which we feel would have been appropriate in the circumstances.

At HMP Chelmsford, there were multiple failings in recording and communicating pertinent information relating to Dean's circumstances. These included but are not limited to:

- *Discrepancies between various official records;*
- *Failure to provide full explanations in recorded entries;*
- *Failure to record key incidents;*
- *A complacent approach to Dean's state of mind and circumstances.*

There was an absence of clinical leadership in the healthcare wing of HMP Chelmsford. There was confusion regarding the head of healthcare's qualifications by members of staff.

The administration and performance of ACCT reviews was wholly inconsistent

	and record keeping incomplete. Such as confirming a case manager throughout the ACCT, confirming risk level on 24th December and other information that must be completed in every case. *Finally there was a total lack of consistency and logic regarding the level of risk ascribed to Dean's situation and consequent levels of observation.* *On 4th January 2016, the performance of the observations was perfunctory as the member of staff did not engage with Dean as required in the PSI and checks were not carried out on an irregular basis.* *There was a failure to transfer Dean to a medical facility as the section 48 process in operation at HMP Chelmsford is contrary to industry best practice.* *In addition the psychiatric assessment on 21st December failed to take into account the fact that Dean's observation levels had been reduced at the ACCT meeting earlier that day.* *In summary, Dean SAUNDERS and his family were let down by serious failings in both mental health care and the prison system.*
4	**CIRCUMSTANCES OF THE DEATH** Dean Saunders was 25 years old at the time of his death. On 16 December 2015 he was detained under s136 Mental Health Act and assessed at Rochford Hospital. He was discharged to his parents' home where an incident took place involving him stabbing two family members and threatening to take his own life. He was arrested and taken to Basildon Police Station. On 17 December 2016 Mr Saunders was assessed and not made subject to a section of the Mental Health Act. He was charged with two counts of attempted murder and after an appearance in Basildon Magistrates' Court, he was remanded in custody to HM Prison Chelmsford. An ACCT – Assessment, Care in Custody and Teamwork - document was opened. He was initially placed under constant supervision but this was later reduced to twice hourly observations. Seven ACCT reviews were held between 18 and 31 December. At 10.25am on 4 January 2016 Dean was found unresponsive lying on a mattress in his cell. His death was confirmed and the cause of death provided by the pathologist, [redacted] was 1a) electrocution
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. **FOR SEPT:-** The admitted lacuna in the SEPT admissions protocol governing the transfer of mentally disordered people from police custody. The current admissions protocol does not allow for the transfer of *any* individual from police custody, irrespective of the criminal charges the individual is facing. Cont……

	2. **FOR SEPT AND NHS ENGLAND:-** The absence of a written record of the "best practice" forensic pathway referred to by [redacted] in his evidence, and consideration of whether the transfer of individuals such as Dean to prison is indeed "best practice", taking into account the consequent delay in transfer and the suitability of the prison environment for mentally disordered individuals. 3. **FOR CARE UK, NOMS, SEPT:-** The lack of clarity regarding the hospital transfer process. The evidence at the inquest demonstrated that this is currently shrouded in confusion and contradiction (if the PSI and the NHS England "good practice" is compared). Given that rationalisation of the process is still a "work in progress", the family consider that it should be given urgent consideration. 4. **FOR NOMS:-** Training regarding the ACCT process. In previous prison deaths and in response to previous PPO reports, promises have been made about training having been provided to staff yet the same mistakes are being repeated. Meaningful action in required in this regard. 5. **FOR NHS ENGLAND:-** The resilience of psychiatric cover at Chelmsford prison, which would need to be raised with NHS England who commission such services and decide on the budget. 6. **FOR NOMS:-** The meaningful involvement of families in the ACCT process, including by ensuring the formal recording, and communication of concerns raised by a prisoner's family.
6	**ACTION SHOULD BE TAKEN** In my opinion action should be taken to prevent future deaths and I believe you and 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 14 April 2017. 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. Cont……

8	**COPIES and PUBLICATION** I have sent a copy of my report to the Chief Coroner and to the following Interested Persons – Bindmans, solicitors for the family] 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	**[DATE] 17 February 2017** **Caroline Beasley-Murray**