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:** 1. **Bristol Community Health** **South Plaza** **Marlborough Street** **Bristol** **BS1 3NX** 2. **Avon & Wiltshire Mental Health NHS Trust** **Jenner House** **Langley Park Estate** **Chippenham** **Wiltshire** **SN15 1GG**
	CORONER I am Maria Eileen Voisin, Senior Coroner, for the area of Avon
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 11th March 2016 I commenced an investigation into the death of **Callum Oliver SMITH**, Aged **27**. The investigation concluded at the end of the inquest on 26th May 2017. The conclusion of the jury inquest was: Cause of death 1a) Hanging Conclusion - Callum Smith's death, caused by suicide whilst suffering extreme anxiety and distress was contributed to by the following: • Inadequate attention to the concerns of Callum's family, his own requests for help and for communication with his family, the level of his anxiety and acts of self-harm whilst in police and prison custody. • Failure to record key events on the PER and to include health and mental health records on transfer to prison • Inadequate communication between those involved in Callum's care. • Inadequate mental health assessment and failure to carry out a timely full mental health assessment and to ensure proper referrals took place with handover. • Repeated failures to open an ACCT due to lack of training, inadequate training and staff understanding, failure to take responsibility for the opening of an ACCT and failure to recognise that self-harm extends to intentionally banging head against a wall or door.

	• Inadequate integration between and access to I.T systems which led to key information being missed • Failure to support Callum by not allowing a follow-up assessment to take place.
4	**CIRCUMSTANCES OF THE DEATH** Callum was in the care of HMP Bristol at the time of his death. He was found hanging in his cell by a prison officer.
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. At the conclusion of the inquest I expressed my concern in relation to assessing risk of suicide and self-harm and how from the evidence heard it appeared that there was a possible conflict between how healthcare/mental healthcare staff assess risk in this area and the requirements of the ACCT policy for all staff working with prisoners to follow the requirements of PSI 64/2011. 2. There was evidence that healthcare/mental healthcare staff needed to be reminded of the lower threshold for opening an ACCT and that this is fundamentally different to the way that they carry out an assessment and/or risk assessment of a patients risk of suicide or self harm for medical/mental health care and treatment as per PSI 64/2011. 3. I was concerned that staff who apparently had been trained did not appear to consider that they had when giving evidence and therefore I would ask that this is reviewed to ensure that healthcare/mental healthcare staff receive detailed training on the ACCT process as it is clearly an important and recognized policy in preventing a risk of self-harm or suicide. 4. I indicated that I would ensure that this report was copied to the prison as they would need to be aware of this, as it is often they who provide the ACCT training for healthcare/mental healthcare staff.
6	**ACTION SHOULD BE TAKEN** In my opinion action should be taken to prevent future deaths and I believe you 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 2nd August 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.
8	**COPIES and PUBLICATION** I have sent a copy of my report to the Chief Coroner and to the following Interested Persons – the family and HMP Bristol. I have also sent a copy to the PPO. 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	**7.6.17** **M. E. Voisin**