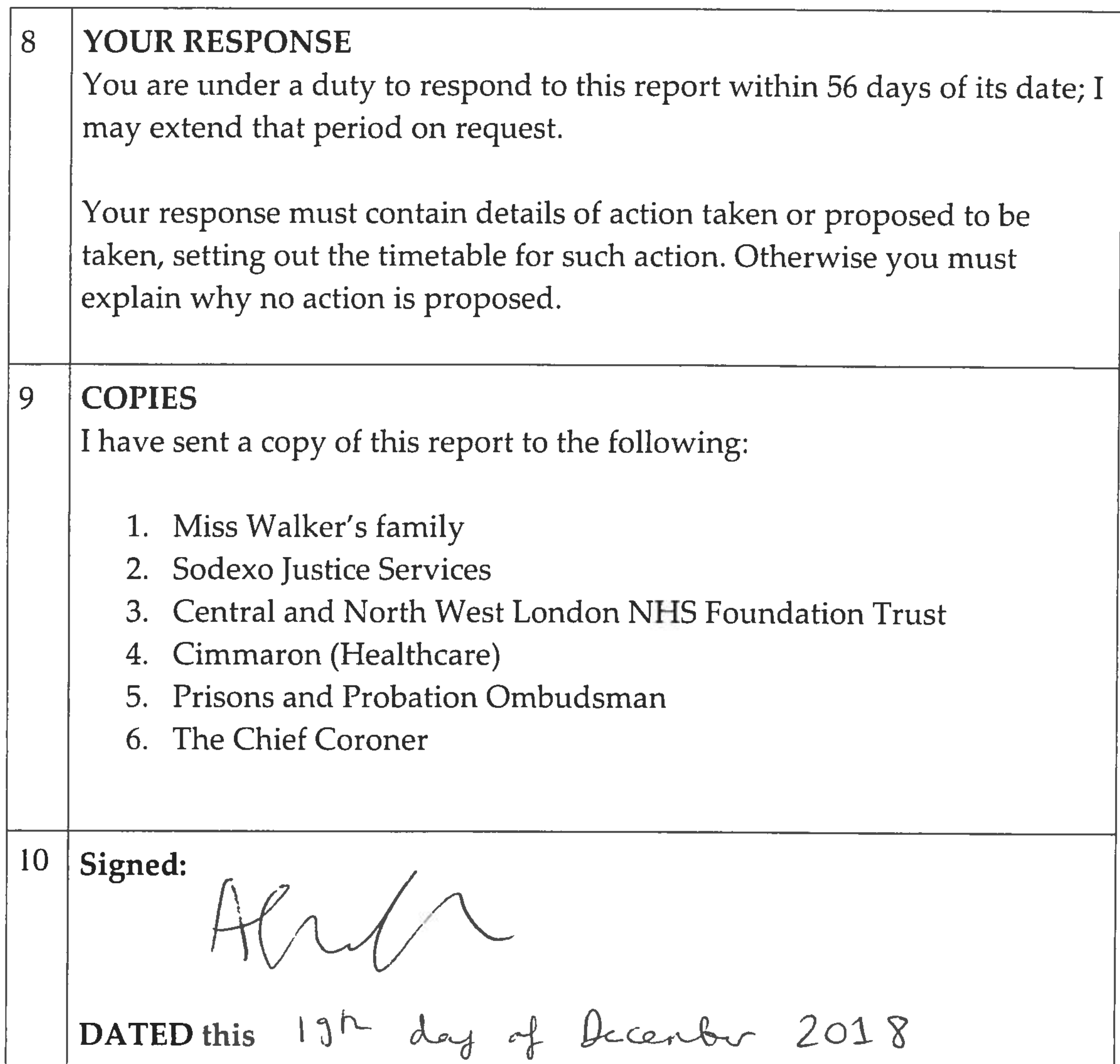
<u>IN THE SURREY CORONER'S COURT</u>
<u>IN THE MATTER OF</u>:

The Inquest Touching the Death of Miss Kirsty Walker
A Regulation 28 Report – Action to Prevent Future Deaths

1	**THIS REPORT IS BEING SENT TO:** • The Rt Hon Matt Hancock MP Secretary of State for Health and Social Care Department of Health and Social Care London SW1H 0EU • Simon Stevens Chief Executive Officer NHS England PO Box 16738 Redditch B97 9PT
2	**CORONER** Miss Anna Crawford, HM Assistant Coroner for Surrey
3	**CORONER'S LEGAL POWERS** I make this report under paragraph 7(1) of Schedule 5 to The Coroners and Justice Act 2009.

4	**INQUEST** The inquest into the death of **Miss Kirsty Walker** was opened on 7 October 2015. It was resumed on 29 October 2018 with a jury. The jury returned their conclusion on 13 November 2018. They found the medical cause of death to have been: 1a. Hypoxic brain injury 1b. Cardiorespiratory arrest 1c. Ligature compression to the neck They concluded with a short-form conclusion of accidental death together with a narrative conclusion.
5	**CIRCUMSTANCES OF THE DEATH** Miss Walker died at St Peters Hospital in Surrey on 27 September 2015. At the time of her death she was 26 years old and serving a prison sentence at HMP Bronzefield. HMP Bronzefield is a private prison run by Sodexo Justice Services, which contracts out secondary mental health services to Central and North West London NHS Foundation Trust (CNWL). Miss Walker had been diagnosed with borderline personality disorder and had a history of self-harming, both in the community and during previous periods of imprisonment. She began her final period of imprisonment at HMP Bronzefield on 24 March 2015 and from 25 March 2015 onwards she was managed under the prison's suicide and self-harm prevention procedures (ACCT procedures). During the period from 25 March until 25 September 2015 Miss Walker engaged in 235 acts of self-harm, with 215 of those acts involving the tying of ligatures around her neck. On 25 September 2015 she was found unresponsive in her cell with a ligature tied around her neck. She was taken by ambulance to St Peter's Hospital but she did not recover and she died at the hospital on 27 September 2015.

6	**CORONER'S CONCERNS** The court heard evidence in relation to the process and timeframes for transferring prisoners under s.47 of the Mental Health Act 1983 to secure hospitals. In particular, the court heard from [REDACTED], a Consultant Forensic Psychiatrist and the Clinical Director of CNWL Offender Care as well as two other Consultant Forensic Psychiatrists acting as independent experts, [REDACTED] and [REDACTED] The court heard that where a prisoner is assessed as being detainable under the Mental Health Act 1983, they ought to be transferred to hospital within 14 days, pursuant to the recommendations in the 2009 Bradley Report. However, the court heard that the process for carrying out such transfers is in fact a long and convoluted process and that the 14-day timeframe envisaged in the Bradley Report is not complied with as a matter of practice. [REDACTED] told the court that the average waiting time at HMP Bronzefield for transfer to a secure hospital bed is 2-3 months, and that this compares well as against the waiting times at other prisons. [REDACTED] told the court that the average waiting time for transfer to a secure hospital bed in London was 10-12 months. [REDACTED] told the court that in his opinion the lengthy waiting times were due primarily to a dearth of secure hospital beds across the country. The **MATTER OF CONCERN** is: I am concerned that the average time to transfer a prisoner to a secure hospital under s.47 of the Mental Health Act 1983 is well in excess of the 14 days envisaged by the 2009 Bradley Report and presents a risk of further deaths.
7	**ACTION SHOULD BE TAKEN** In my opinion action should be taken to prevent future deaths and I believe that the people listed in paragraph one above have the power to take such action.



8	**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.
9	**COPIES** I have sent a copy of this report to the following: 1. Miss Walker's family 2. Sodexo Justice Services 3. Central and North West London NHS Foundation Trust 4. Cimmaron (Healthcare) 5. Prisons and Probation Ombudsman 6. The Chief Coroner
10	**Signed:** **DATED this** 19th day of December 2018