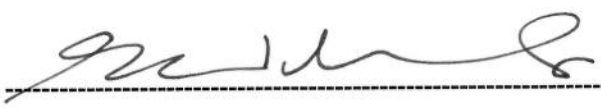
ANNEX A

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:** **1. HM Prison service and HMP Hewell** **2.** **3.**
1	**CORONER** I am Geraint Urias Williams, Senior Coroner, for the coroner area of Worcestershire
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 9th of May 2016 I commenced an investigation into the death of Kelvin Sean Speakman then aged 30 years. The investigation concluded at the end of the inquest on 7th of December 2018. The conclusion of the inquest was Set out in a questionnaire format (attached) the medical cause of death being Pneumonia caused by a hypoxic cerebral injury consequent upon ligature suspension .
4	**CIRCUMSTANCES OF THE DEATH** Mr Speakman was a serving prisoner at HMP Hewell and who had a long history of mental ill-health and extensive self harming acts including multiple attempts to hang himself. He was for most of his time at HMP Hewell monitored under the ACCT process. Ultimately following an incident of self ligaturing he suffered a hypoxic brain injury and was admitted into the Alexandra Hospital in Redditch where he declined and, on 9 May 2016, he died
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) The evidence in the case disclosed that the ACCT process was not handled completely in accordance with national and local policies and in particular the standard of documentation was often inadequate. The input to ACCT reviews by the health care department was often absent or the content of such input was not clearly identified. Communication between various staff members was either not consistent or documented leading to a conclusion that staff members making decisions about Mr

	Speakman were not aware of the full picture of his presenting condition. Although the evidence suggested that more was being done for him than the documentation might suggest it was clear from the evidence that there were gaps in information and potentially in the actions being undertaken. This is not the 1st inquest into a death at HMP Hewell where these criticisms have been made (frequently commented upon in successive PPO reports). In this and earlier inquests the prison have accepted the recommendations made by the PPO to improve the operation of the ACCT process and have given assurances that "lessons have been learned". However this case has highlighted the fact that notwithstanding those assurances the same failings appear time and time again. Furthermore deaths at HMP Hewell subsequent to Mr Speakman's and which are due to be heard at inquest later this year demonstrate clearly that the same failings exist and are perpetuated. I consider that the entirety of the operation of the ACCT process within HMP Hewell is in need of urgent and radical overhaul for the protection of prisoners being looked after under its auspices. (2) (3)
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 25th April 2019 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 next of kin of the deceased, Care UK, Midlands Partnership . I have also sent it to who may find it useful or of interest. 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	**Signed**  ---------- **G U Williams** **27 day of February 2019** **H M Senior Coroner**