	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO: HMP Birmingham, the Ministry of Justice, G4S**
1	**CORONER** I am Emma Brown, Area Coroner for **Birmingham and Solihull**
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 01/05/2018 I commenced an investigation into the death of Marcus William George McGuire. The investigation concluded at the end of an inquest on 17th June 2019. The conclusion of the inquest was ascertained by the Jury completing a questionnaire that confirmed that the Deceased died as a result of suicide which was possibly contributed to by: 1) Failing to carry out a mental health assessment; 2) The fact that no action was taken in response to Marcus refusing or failing to take his prescribed anti-psychotic medication every day between 13 April 2018 and 23 April 2018. 3) The failure In relation to the ACCT that was opened on 19 March 2018 to involve the mental health team. 4) The assessment within the ACCT that Marcus was at 'LOW' risk (of self-harm and/or suicide) which was not based on all relevant and available evidence. 5) Failings within the management of the ACCT to complete the care map, to close the ACCT, to conduct a post closure assessment, to re-open the ACCT.
4	**CIRCUMSTANCES OF THE DEATH** (as taken from the Jury's conclusions at Question 3 of the Record of Inquest) Mr McGuire died at HMP Birmingham on 24 April 2018 between the hours of 12.45am - 8.45am when he was found in cell D1, 15 with no signs of life, cold to touch, early signs of rigor mortis, with a ligature around his neck. ~~~ On 1st February 2018 Mr McGuire was transferred from HMP Oakwood to HMP Birmingham due to aggressive behaviour. A mental health referral had been made at HMP Oakwood but was unable to be carried out due to combative behaviour. An inadequate reception screening took place at HMP Birmingham on arrival with failure to refer Mr McGuire to mental health. A follow up email on 19 February by HMP Oakwood referred Mr McGuire for a mental health assessment. This was not actioned and he was discharged on 26th February 2018. On 19 March 2018, Mr McGuire was found in his cell D1, 15 with a severe cut to his left wrist which was potentially life threatening, a second cut was later found on his right wrist. He was sent to City Hospital. An ACCT book was immediately opened. The concern and keep safe form lacked detail, a failure to comply with ACCT guidance. Whilst in hospital on 21 March 2018, Mr McGuire gave a statement of intent to commit suicide. This was logged appropriately. He returned to hospital on 22nd March 2018 and was seen on 23 March 2018 for the ACCT assessment interview. Insufficient information was gathered, mental health was not consulted against ACCT Book guidance. The assessment form was lacking detail and a CPN referral was suggested. The first case review immediately followed. The first line manager for D Wing was not trained in case management and an appropriate manager was in attendance. Mr McGuire's risk was assessed as low without all pertinent available information. Mental health was not present and the case map was not filled out, all against ACCT book guidance. Subsequent case reviews up to the 5th April all failed to follow ACCT guidance including inconsistencies in case management, care maps not appropriately filled out, pertinent history not consulted and no mental health care present. This resulted in a consistent low risk assessment and the ACCT was placed

	into post closure on 5 April. All observations were stopped, not reduced, as guidance suggests. During this time, there were several incidents, prior to post closure involving Mr McGuire, including signs of paranoia and aggressive behaviour. The mental health assessments were booked but neither were completed. Having asked twice previously for his medication to be amended, Mr McGuire refused his medication on 12 April and a more serious refusal on 13 April, having an altercation with a nurse. Mental health subsequently visited Mr McGuire for triage but no full assessment was ever completed. The ACCT book was not found to document visit. On the same day, an inappropriate post closure review was recorded. No paperwork was completed and there was further failure to comply with ACCT guidance. Mr McGuire missed his third dose of medication on 15 April and there was failure to notify proper channels. He took no further medication until one dose on 23rd April. On 23rd April Mr McGuire was last spoken to at approximately 9pm and was then found deceased at approximately 8.45am following constriction by ligature around the neck on 24th April 2018. Prior to Mr McGuire's death there was a shortage of ACCT trained staff leading to case management inconsistencies, repeated failure to check pertinent information and failure to adhere to ACCT guidance including the closure of the book. Mental health care was not appropriately involved at any stage of Mr McGuire's stay at HMP Birmingham. Following a post mortem the medical cause of death was determined to be: 1a) CONSTRICTION BY LIGATURE AROUND THE NECK
5	**<u>CORONER'S CONCERNS</u>** 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. Many of the deficiencies in Mr. McGuire's ACCT plan, such as the absence of a properly completed care plan, the failure to involve the mental health team, failure to consider all relevant and available information and failure to carry out an effective post-closure review, were attributable to the absence of an identified case manager which resulted in different members of staff chairing his case reviews and no-one taking responsibility to follow up on action points. 2. At the time of Mr. McGuire's death it was not uncommon for ACCTs not to have an identified case manager. 3. Evidence was given at inquest that there has been an increase in the number of trained case managers to enable all ACCTs to have a designated single case manager who will remain the case manager for the life of the ACCT so far as reasonably possible and where a change is required, there is a formal hand-over process. 4. Following completion of the evidence, the Report on an independent review of progress at HMP Birmingham by H. M. Chief Inspector of Prisons based on an inspection of the 7th to 9th May 2019 was brought to my attention. Paragraph 2.27 of the report provides: *"The quality of ACCT casework was not yet good enough. In response to our concern at the last inspection, managers had sought to deliver single case management and provide prisoners in crisis with activities. This ambition has not yet been realised. None of the eight cases we checked had a single case manager…"* 5. I am also aware that in a letter dated the 11th June 2019, [redacted], Head of Custodial Contracts responded to the Report on the review of progress on behalf H. M. Prison & Probation Service. In the response it is recognised that *"we need to do more to embed single case management".* 6. I am concerned that I was given the impression that single case management is embedded at HMP Birmingham: if I had been aware that it was not, I would have sought additional evidence on why, what needed to be done to "*embed"* single case management and how it is intended to achieve it. 7. I am concerned that the disparity between the evidence given to me and the findings upon

	inspection 6 weeks earlier indicates that Managers at HMP Birmingham are either not aware of or not conveying the reality of the extent to which improvements in the ACCT process have been achieved. 8. The absence of an embedded system of single case management will put lives at risk as compliance with the ACCT process cannot be assured.
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 21st August 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 family of Mr. McGuire, Birmingham Community Healthcare NHS Trust and Birmingham and Solihull Mental Health NHS Foundation Trust. 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	23/06/2019 Signature  Emma Brown Area Coroner **Birmingham and Solihull**