Regulation 28: REPORT TO PREVENT FUTURE DEATHS (1)

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

REGULATION 28 REPORT TO PREVENT DEATHS

THIS REPORT IS BEING SENT TO: [redacted], Governor HMP Woodhill

1 CORONER

I am Tom OSBORNE, Senior Coroner for the area of Milton Keynes

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 08/01/2019 I commenced an investigation into the death of Darren Barry WILLIAMS aged 39. The investigation concluded at the end of the inquest on 05/11/2019. The conclusion of the Jury at the inquest was: Suicide

4 CIRCUMSTANCES OF THE DEATH as recorded by the jury

Darren Williams was detained at HMP Woodhill from 2nd May 2018.

On 4th January on House Unit 1a in cell 1-12 at 15.49pm he was found hanging from a bed frame.

Based on the balance of probability the Jury find it more likely than not, that Darren took his own life and intended to do so.

In the circumstances leading up to the death of Darren Williams the Jury found that there was a consistent failure to follow due process and relevant protocols:
- ACCT procedures and protocols were not followed
- As an integral part of the ACCT process there was a significant failure to complete and allocate actions in Care Maps
- Rule 45 applications were not documented or correctly considered
- Information was not suitably shared between the effected departments

During Darren Williams time at HMP Woodhill the Jury have heard evidence that he refused to engage with some aspects of the support offered. However, the jury finds that the support provided was inadequate and lacking in key areas such as violence reduction, victim support, mental health and family engagement.

Given Darren Williams' history of long term drug abuse and the accrual of debt whilst at HMP Woodhill it was vital these services were offered in full.

5 CORONER'S CONCERNS

The MATTERS OF CONCERNS are as follows: (brief summary of matters of concern)

I have two concerns; firstly, it became apparent during the course of the evidence that ACCT reviews were being conducted on many occasions without someone from Healthcare being in attendance.

Secondly in this particular case there were four separate ACCT's and it was apparent that not all relevant information available from previous ACCT's was taken into consideration when a new ACCT was opened.

6 ACTION SHOULD BE TAKEN

In my opinion action should be taken to prevent future deaths and I believe you (and/or your organisation) have the power to take such action.

With regard to my first concern, I would request that consideration be given to make the requirement for attendance by someone from healthcare, who has knowledge of the prisoner/patient mandatory at first reviews and when the decision is made to close the ACCT. In addition if they do not attend the review should be postponed.

In terms of the ACCT, I would ask for consideration to be given to a local policy whereby if an ACCT has been opened for a particular prisoner and subsequently closed, if there is a subsequent event requiring the protection of an ACCT the previous one should be reopened rather than an entirely different document. This would go some way to ensure continuity and would make the first Care Map available to the staff.

7 YOUR RESPONSE

You are under a duty to respond to this report within 56 days of the date of this report, namely by 1st January 2020. 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 Williams
Central North West London NHS Foundation Trust

I have also sent a copy to the Independent Monitoring Board, 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.

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Tom OSBORNE
Senior Coroner for
Milton Keynes
Dated: 06 November 2019