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. [redacted], Governor of HMP Long Lartin**
1	**CORONER** I am David Donald William Reid, 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 29.3.18 an investigation was commenced into the death of David John KIRSCH, a prisoner at HMP Long Lartin, who was then 52 years of age. This investigation concluded at the end of the inquest on 29.10.19. The conclusion of the inquest was that Mr. Kirsch died as the result of suicide, the medical cause of death being: 1a Haemorrhage; 1b Incised wound right side of neck.
4	**CIRCUMSTANCES OF THE DEATH** Mr. Kirsch, who had previously attempted to take his own life on 20.1.18 and 21.1.18, was found deceased in his cell on the evening of 19.3.18, having used the lid of a tin to inflict a large wound to his neck which involved the external jugular vein. At the time of his death, Mr. Kirsch had been the subject of an ACCT document since 20.1.18.
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) No Case Manager had been allocated to oversee Mr. Kirsch's ACCT document. This lack of oversight resulted in a number of deficiencies in the ACCT process, including: (a) 11 different people chairing the 13 ACCT reviews which took place in the 6 weeks between Mr. Kirsch's return from hospital on 5.2.18 and his death on 19.3.18; (b) Inadequate completion of the Caremap within the ACCT document, which ought to have highlighted the issues behind Mr. Kirsch's concerning behaviour and suicide attempts in January 2018, and identified actions to be taken to try to address those issues. In this case, evidence was heard that: (i) When he had first started his sentence in 2008, Mr. Kirsch had told people that he would not live to complete it; (ii) In August 2017 he had had two notable episodes of bizarre behaviour

which, it was thought, may have been down to having taken the psychoactive substance Spice

(iii) Evidence from staff who had witnessed the suicide attempts in January 2018 indicated that they thought he may have taken Spice on those occasions;

(iv) Throughout 2017 and early 2018 he had been rather obsessed with a complaint he had made about an entry on his NOMIS record, and that in the days leading up to his death he had reported that this had been keeping him up at night;

(v) He was concerned that his daughter, who had become an adult relatively recently, had not tried to make contact with him;

(vi) He was worried about visits from his family, and how he was going to tell them what he had done in January 2018;

(vii) He had been involved in a fight on 13.3.18 with another prisoner (something out of character for him), which had resulted in his transfer to another wing, away from a fellow prisoner who was an important part of his support network;

(viii) He had recently sought out a member of the healthcare team in tears, because he was worried that he had not been able to get across his version of events in the adjudication hearing held after the fight incident;

(ix) On the afternoon of his death, two fellow prisoners had expressed concerns to a Supervising Officer that Mr. Kirsch was "looking particularly down" and was not himself. This conversation was passed on to the Supervising Officer on Mr. Kirsch's wing who spoke to him. In that conversation, Mr. Kirsch made a concerning comment about having bitten someone, and denied (untruthfully) that he had had any involvement with the mental health team at the prison. These concerns and conversations were not recorded anywhere in the main body of the ACCT document.

Save for the fact of the fight on 13.3.18 and of his resulting transfer to another wing, none of these matters was noted in the Caremap on Mr. Kirsch's ACCT document, and so no actions were identified to try to address them.

(c) The ACCT document was opened on 20.1.18. Between then and 5.2.18 Mr. Kirsch had been receiving treatment for his injuries in hospital, and had been on constant bedwatch there. When he returned to the prison on 5.2.18, no entries were made to the Caremap at all for the first four weeks thereafter.

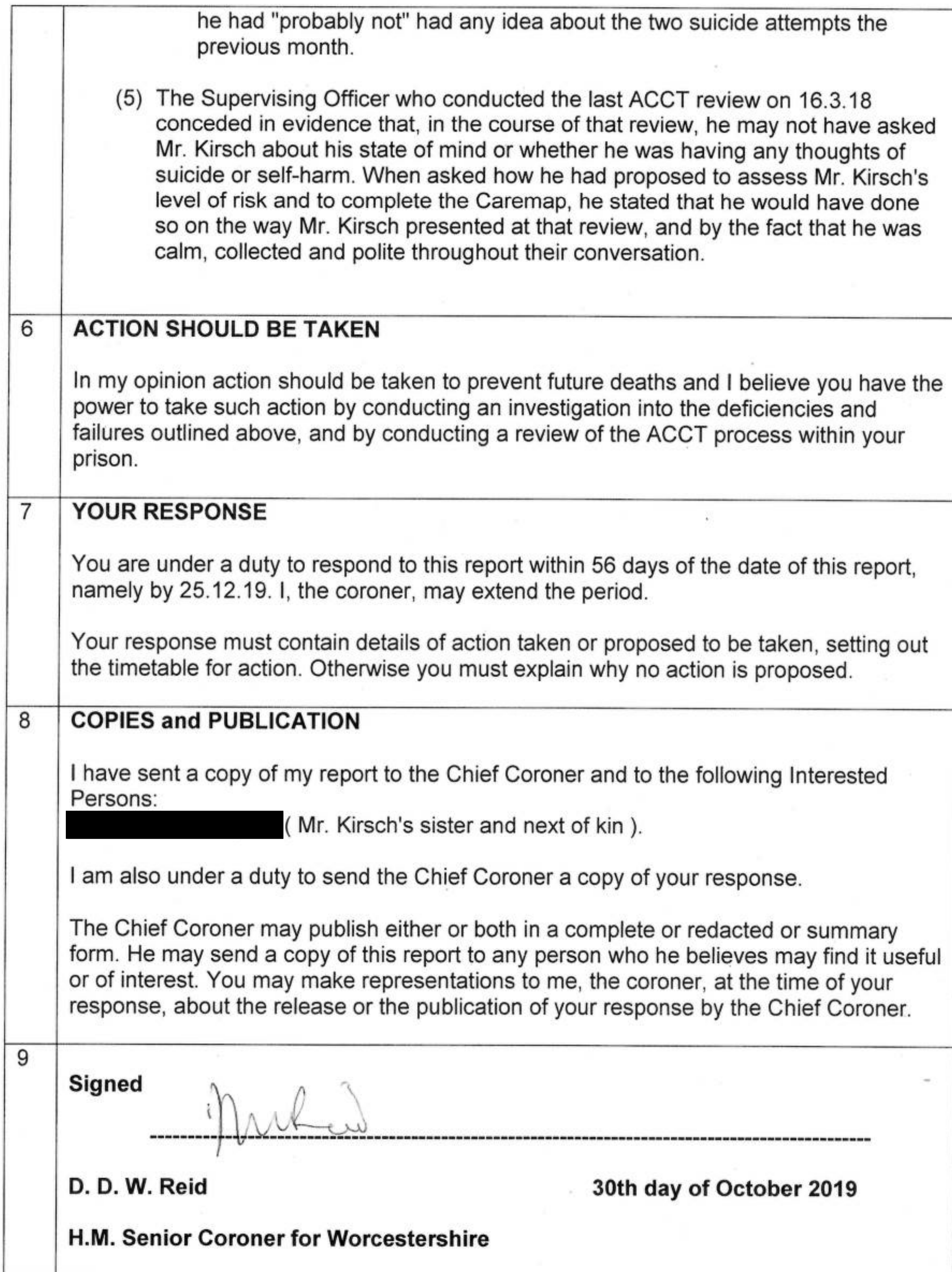
(2) The person whose name had been entered as Case Manager on the ACCT document [redacted] confirmed in evidence that he was not aware of this, and had never had any involvement with this ACCT document because he had not been told about it. More worryingly, another unknown person appears to have signed off the first page of the Caremap using [redacted] initials.

(3) Despite the ACCT document having been open for more than 6 weeks, it was not escalated to a more senior member of staff, as per prison policy.

(4) Some prison officers appeared to have had a worrying lack of knowledge of the reasons for the ACCT document being opened, and of the issues set out therein which needed to be monitored. By way of example:

(a) the Supervising Officer on Mr. Kirsch's wing who had the conversation with him described at 1(b)(ix) above, was not aware that DK had attempted suicide twice in January 2018, and had not realised that Mr. Kirsch was being untruthful about his involvement with the mental health team;

(b) another Supervising Officer who had conducted an earlier ACCT review on 8.2.18 also conceded in evidence that at the time he conducted the review



he had "probably not" had any idea about the two suicide attempts the previous month.

(5) The Supervising Officer who conducted the last ACCT review on 16.3.18 conceded in evidence that, in the course of that review, he may not have asked Mr. Kirsch about his state of mind or whether he was having any thoughts of suicide or self-harm. When asked how he had proposed to assess Mr. Kirsch's level of risk and to complete the Caremap, he stated that he would have done so on the way Mr. Kirsch presented at that review, and by the fact that he was calm, collected and polite throughout their conversation.

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 by conducting an investigation into the deficiencies and failures outlined above, and by conducting a review of the ACCT process within your prison.

7 YOUR RESPONSE

You are under a duty to respond to this report within 56 days of the date of this report, namely by 25.12.19. 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:
(Mr. Kirsch's sister and next of kin).

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

D. D. W. Reid **30th day of October 2019**

H.M. Senior Coroner for Worcestershire