Mid Kent and Medway Coroners

Cantium House
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[redacted]

	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO:** 1. The Governing Governor, HMP Elmley 2. [redacted], Director General, Prisons
1	**CORONER** I am Ian Brownhill, assistant coroner, for the coroner area of Mid Kent and Medway
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** James Devenny died on 2 September 2019 at HMP Elmley, aged 34 years. An investigation into his death was commenced. The investigation concluded at the end of the inquest on 18 May 2021. The jury found that the medical cause of Mr Devenny's death was hanging. Their conclusion was that he died of an accidental death and there was a failure to open an ACCT document which caused or contributed to his death. The jury also found a series of factors possibly contributed, as explained further under section 4 below.
4	**CIRCUMSTANCES OF THE DEATH** James Devenny died in his single occupancy cell on House Block 2 in HMP Elmley at some point between 1433 and 1558 on 2 September 2019 when he was found, hanging from a light fitting in his cell using a ligature made from a bedsheet. Prior to his death Mr Devenny had been isolated in his cell due to a concern that he posed a risk of violence. The jury found that Mr Devenny's Death was possibly contributed to by the following factors: (1) Staff on houseblock 2 at HMP Elmley were not aware of information as to his history of self-harm which occurred before he arrived there.

	(2) Following the decision to keep Mr Devenny separated from other prisoners, there was not an assessment by a medical professional as to whether he was fit to be separated. (3) The response of the mental health in reach team to referrals in respect of Mr Devenny was not appropriate. In addition, the jury noted in their narrative that: (1) *We feel that lack of access to a phone in cells, to contact support services was inadequate*
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 could 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) In the absence of telephones which are installed directly into the cell, there is no direct means for a prisoner to contact the Samaritans. In the event that a prisoner does not have access to a telephone they are reliant on staff to convey them to a telephone so they may call. There is a particular difficulty in respect of prisoners who are deemed to pose a risk of violence and who may not be able to immediately access a telephone, a listener or a member of Chaplaincy. (2) Prison Officers are not routinely briefed as to prisoners who have previously significantly self harmed in custody. It is not clear as to the threshold of severity required before prison staff will be informed save that they will be informed if a prisoner arrives with an open ACCT. Prison Officers are not routinely briefed as to a prisoner's previous or antecedent pattern of thoughts, feelings, events and behaviours which have led to incidents of significant self-harm.
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 **20 July 2021**. 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 The family of James Devenny Oxleas NHS Foundation Trust IC24 The legal representatives of the above. In addition, I have sent this to:

	[redacted], Her Majesty's Inspector of Prisons [redacted], Chair of the Independent Panel on Deaths in Custody I may also send a copy of your response to any other person who I believe may find it useful or of interest. 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.
9	 Signature: Ian Brownhill Assistant Coroner Mid Kent and Medway 25 May 2021