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. The Governor, HMP Birmingham, Winson Green Road, Birmingham B18 4AS.**
1	**CORONER** I am David Donald William Reid, HM 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 9.5.19 an investigation was commenced into the death of Saul Richard THOMAS, a prisoner at HMP Hewell who died in his cell at the prison on 19.5.19 having [redacted]. He was 42 years of age at the time of his death. This investigation concluded at the end of the inquest on 10.12.21. The medical cause of death was: [redacted] The conclusion of the inquest was as follows: *"Saul Thomas died as a result of [redacted]. It is not possible to determine what his intention was at the time he did this.* *See Questionnaire:* *1. Was Saul's mental health adequately assessed and managed by healthcare at HMP Birmingham? NO* *2. If NO to Question 1:* *(a) did a failure to assess and manage Saul's mental health at HMP Birmingham probably cause or contribute to his death on 19 May 2019? NO* *(b) If NO or CANNOT SAY to Question 2(a), did a failure to assess and manage Saul's mental health at HMP Birmingham possibly cause or contribute to his death on 19 May 2019? YES* *3. Do you consider that an ACCT suicide/self-harm mitigation plan should have been opened at HMP Birmingham on or at any stage after 11 May 2019? YES* *4. If YES to Question 3:* *(a) did a failure to open an ACCT on or at any stage after 11 May 2019 at HMP Birmingham probably cause or contribute to his death on 19 May 2019? YES* *(b) if NO or CANNOT SAY to Question 4(a), did a failure to open an ACCT on or at any stage after 11 May 2019 at HMP Birmingham possibly cause or contribute to his death on 19 May 2019?*

5. Was the outgoing handover about Saul from HMP Birmingham to HMP Hewell satisfactory? NO

6. If NO to Question 5:
(a) did that unsatisfactory handover probably cause or contribute to Saul's death on 19 May 2019? NO
(b) if NO or CANNOT SAY to Question 6(a), did that unsatisfactory handover possibly cause or contribute to Saul's death on 19 May 2019? YES

7. Did HMP Hewell deal with the handover about Saul from HMP Birmingham in a satisfactory way? NO

8. If NO to Question 7:
(a) did the unsatisfactory way in which HMP Hewell dealt with the handover probably cause or contribute to Saul's death on 19 May 2019? YES
(b) if NO or CANNOT SAY to Question 8(a), did the unsatisfactory way in which HMP Hewell dealt with the handover possibly cause or contribute to Saul's death on 19 May 2019?

9. Was the mental health referral made by healthcare at HMP Hewell 2019 adequate? NO

10. If NO to Question 9:
(a) did the inadequate mental health referral at HMP Hewell probably cause or contribute to Saul's death on 19 May 2019? YES
(b) if NO or CANNOT SAY to Question 10(a), did the inadequate mental health referral at HMP Hewell possibly cause or contribute to Saul's death on 19 May 2019?

11. Was information shared and considered adequately by healthcare staff at HMP Hewell? NO

12. If NO to Question 11:
(a) did inadequate sharing and consideration of information by healthcare at HMP Hewell probably cause or contribute to Saul's death on 19 May 2019? YES
(b) if NO or CANNOT SAY to Question 12(a), did inadequate sharing and consideration of information by healthcare at HMP Hewell possibly cause or contribute to Saul's death on 19 May 2019?

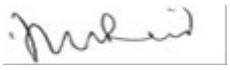
13. Was Saul's mental health adequately assessed and managed by healthcare at HMP Hewell? NO

14. If NO to Question 13:
(a) did the failure by healthcare to adequately assess and manage Saul's mental health at HMP Hewell probably cause or contribute to his death on 19 May 2019? YES
(b) if NO or CANNOT SAY to Question 14(a), did the failure by healthcare to adequately assess and manage Saul's mental health at HMP Hewell possibly cause or contribute to his death on 19 May 2019?

15. Should an ACCT [redacted] *mitigation plan have been initiated by prison staff at HMP Hewell? YES*

16. If YES to Question 16:
(a) did the failure by prison staff at HMP Hewell to open an ACCT probably cause or contribute to Saul's death on 19 May 2019? YES
(b) if NO or CANNOT SAY to Question 16(a), did the failure by prison staff at HMP Hewell to open an ACCT possibly cause or contribute to Saul's death on 19 May 2019?

	17. Was Saul Thomas' death contributed to by neglect? YES
4	**CIRCUMSTANCES OF THE DEATH** In answering the questions "when, where, how and in what circumstances did Mr. Douglas come by his death?", the jury found as follows: *"On 19/5/19 Saul Thomas died at HMP Hewell, [redacted] in his cell."* To clarify, Mr. Thomas was remanded into custody to HMP Birmingham, charged with a number of serious offences, on 15.4.19. This was his first experience of custody. He had a recent history of drug-induced paranoia, linked to his heavy use of cocaine, and whilst at HMP Birmingham was transferred to the mental health ward within the Inpatients Unit, so that his mental health could be formally assessed. During his time at HMP Birmingham, Mr. Thomas continued to express paranoid thoughts, particularly that other people were looking to harm him and that he would be killed. Following a court hearing on 16.5.19, he was transferred to HMP Hewell. Both prisons failed to ensure that HMP Hewell were made aware of the concerns over Mr. Thomas' mental health and the fact that he was undergoing psychiatric assessment within the Inpatients Unit at HMP Birmingham before his transfer. Once at HMP Hewell, he was placed on an ordinary prison wing. It was recorded that he felt under threat, but didn't know why. On the morning of 19.5.19 Mr. Thomas was found unresponsive in his cell at HMP Hewell, having [redacted]. He was confirmed deceased some 30 minutes later.
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) In the questionnaire which formed part of their conclusion, the jury found that an ACCT document should have been opened for Mr. Thomas at HMP Birmingham at some point after 11.5.19, and that a failure so to do probably caused or contributed to his death. I heard evidence from a senior member of staff at the prison that as many as a third of all staff at HMP Birmingham still do not have up-to-date training relating both to [redacted] and to the ACCT process. I was also concerned to hear from one prison officer that he had had no ACCT training since 2014. Until such training is provided to all staff working at the prison, there remains a risk of similar deaths occurring in the future; (2) In the questionnaire which formed part of their conclusion, the jury found that the unsatisfactory handover about Mr. Thomas provided by HMP Birmingham to HMP Hewell possibly caused or contributed to his death. I heard evidence from a senior member of staff at HMP Birmingham that (a) prison staff there should have alerted their counterparts at HMP Hewell to the fact that Mr. Thomas had been undergoing psychiatric assessment within the Inpatients Unit there; and (b) that this was still a concern which needed to be looked into. I was concerned to hear that, whilst this failing has been recognized by HMP Birmingham, no action has been taken to ensure that it will not be repeated. Until action is taken to ensure that handovers between prisons include such important information, there remains a risk of similar deaths occurring in the future.

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 ensuring that appropriate training is provided to all relevant 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 15.2.22. 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: Deighton Pierce Glynn solicitors, who represent Mr. Thomas' family; Government Legal Department, who represent HM Prison Service; Browne Jacobson LLP, who represent Birmingham Community NHS Foundation Trust and Birmingham and Solihull Mental Health NHS Foundation Trust; Practice Plus Group Midlands Partnership NHS Foundation Trust; The Prison and Probation Ombudsman. 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** **21st December 2021** **H.M. Senior Coroner for Worcestershire**